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ABSTRACT

The chapters of this "monograph" reflect the philosophies of 14 health educators who represent a variety of work settings: (1) "This I Believe: A Philosophy of Health Education" (Loren B. Bensley, Jr.); (2) "Educating about Health" (William B. Cissell); (3) "Some Guiding Principles on Health and Health Education: A Philosophical Statement" (Charles R. Carroll); (4) "Pondering a Professional Philosophy" (Judy C. Drolet); (5) "The Role of Health Education in Worksite Health Promotion" (James M. Eddy); (6) "Health Education: Building Professional Bridges To Span the Decades" (Nancy T. Ellis); (7) "Health Education: A Smorgasbord of Life" (Joyce V. Fetro); (8) "Would I Do It All Over?" (Marian V. Hamburg); (9) "Changing Expectations of Health Education" (Joyce W. Hopp); (10) "One Person's Philosophy of Health Education: 1993" (Susan Cross Lipnickey); (11) "Reflections of a School Health Educator/Administrator" (David K. Lohrmann); (12) "Three Essential Questions in Defining a Personal Philosophy" (R. Morgan Pigg, Jr.); (13) "Andy's Question" (Candace O. Purdy); and (14) "Health Education and the Pursuit of Personal Freedom" (John R. Seffrin). (LL)

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The Eta Sigma Gamma

Monograph Series

REFLECTIONS: THE PHILOSOPHIES OF HEALTH EDUCATORS OF THE 1990'S

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The Eta Sigma Gamma Monograph Series

Volume 11 Number 2
December 1993

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Errata to The Eta Sigma Gamma Monograph Series, Volume 11(1), July, 1993:

In my article. Barnes, M.D. (1993). A wellness week for elementary schools. *Eta Sigma Gamma Monograph Series, 11*(1), 1 - 5, I regret that the following reference and citation information was omitted:

Patterson, S.M., Naing, K., & Scott, V. (1991). *Wellness weeks in elementary schools: Five years of a successful school community partnership.* 1991 School Health Education and Services Sesson Abstracts, American Public Health Association, Atlanta, Georgia.

I apologize for the mistake and request that the reference and citation be acknowledged.

Reflections: The Philosophies of Health Educators of the 1990's

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FOREWORD

The rationale for this monograph is based on the notion that our beliefs or ways of thinking about health education represent our philosophy. Yet, we seldom put these beliefs in writing, even though they impact how we function.

Included in this monograph are the "philosophies" of fourteen health educators. The authors represent a variety of work settings: public schools (K-12), colleges and universities, voluntary organizations, and foundations. They also represent positions of teachers, professors, and administrators.

Each of the selected authors was invited to submit an article of approximately 2000 words. They were encouraged to feel free to develop and structure their presentation according to the forces and factors impacting their lives. The following trigger questions were suggested as possible thought provokers.

Trigger Questions

1. What principles guide you as you practice in the profession of health education?

2. What forces and factors have influenced you most in the profession?

3. What signposts have been most meaningful to you in the profession?

4. Is there an article(s) or book(s) that has (have) been influential in shaping what you believe about health education?

5. What is the future of health education?

Collectively, the articles represent a tapestry of thinking; within each are ideas and issues, concepts and credos which reflect direction of the authors functioning as a health educator. Many have referred to people and experiences significant to their personal and professional lives; others have used a more formal and substantive approach; still others have used history as direction for their thinking.

No editorial comments are necessary; the authors have written with clarity and honesty. The hope is that these articles will illuminate and empower the philosophical truths and spirit of health education for the twenty~first century.

Mary K. Beyrer, Ph.D.

Ann E. Nolte, Ph.D.

Dedicated to

Elena M. Sliepcevich

Professor Emeritus
Southern Illinois University

Colleague - Mentor - Friend

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PREFACE

It is a great honor for me to serve as the new Editor of the Eta Sigma Gamma Monograph Series. This is an exciting opportunity for me and I look forward to hearing your comments and suggestions regarding the Monograph Series.

As Editor, I would like to express my special thanks to the Guest Editors of this issue, Dr. Mary K. Beyrer and Dr. Ann E. Nolte, for the great contributions they have made to the profession and Eta Sigma Gamma. They have gone above and beyond the call of duty in preparing this first-class monograph and they deserve our heartfelt appreciation. Further, I would like to thank each and every one of the authors who ultimately made this monograph possible. I genuinely appreciate their contributions to the Monograph Series. Also, thank you to Billie Kennedy for all the detail work in making publication of this monograph possible.

Finally, I would like to thank Dr. Judy Luebke for doing an excellent job as the former Editor of the Monograph Series.

Mohammad R. Torabi, Ph.D.

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CHAPTER 1

This I Believe: A Philosophy of Health Education

Loren B. Bensley Jr., Ed.D.

During my undergraduate years, I was given an assignment by a professor to write my philosophy of education. When asked to participate in this monograph series on philosophies of health education, I turned to the assignment that I had done thirty-six years ago. Being a collector of trivia, I knew exactly where to find the assignment. When I read my philosophy, I was amazed at how simple yet clear I stated my beliefs and mission in education. My philosophy reflected that of an inexperienced, naive young man who valued and believed that by choosing to be a teacher, one would have the opportunity to make a difference in others's lives. As a teacher of health, I believed that I could change attitudes of young people so they might resist the temptations which would result in poor decision making. As I continued to read the assignment given to me thirty six years ago, I realized that I still believed in the optimism that I had as a student preparing to be a teacher of health education. Reading my philosophy created a feeling of pride and satisfaction that the mission I had set forth to accomplish has been, to a certain extent, achieved. I am pleased that over the years I haven't become a pessimist or one who has become discouraged with the educational system with its many flaws. It is interesting, while at the same time gratifying, that the values and beliefs of my present philosophy of health education are nothing but an exaggeration of what I believed as an undergraduate about to enter the profession of education. If there has been any change in these beliefs, it has been a stronger

commitment based on my professional and life experiences. What is set forth in the statement that you are about to read is not a new philosophy of health education but one that has existed for a long time and has been resurrected to share with others what I stand for, what I believe in, and what I strive to accomplish.

In developing a personal philosophy of health education, it is necessary to first understand what philosophy means. Philosophy can be defined as a state of mind based on your values and beliefs. This in turn is based on a variety of factors which include culture, religion, education, morals, environment, experiences, and family. It is also determined by people who have influenced you, how you feel about yourself and others, your spirit, your optimism or pessimism, your independence and your family. It is a synthesis of all learning that makes you who you are and what you believe. In other words, a philosophy reflects your values and beliefs which determine your mission and purpose for being, or basic theory, or viewpoint based on logical reasoning.

My personal philosophy of health education includes all of what I am, what I value, and what I believe and stand for in relation to health and education. In other words, in order for me to establish my philosophy of education it was necessary to identify the multitude of factors that have formulated what I believe in, which in turn, has given me direction in establishing my credo or my mission. According to Shirreffs [1976] "all philosophizing begins with the person becoming aware of his/her existence which precedes the establishment of essence in that individual." This being the case, self examination of our existence will help us discover our essence, or our being. Put another way, the reason for our existence reflects our values and beliefs that influence the direction of our professional being or mission.

What then are my values and beliefs, and how have they influenced the development of my philosophy of health education?

Those things that I value have evolved from a multitude of life experiences. Values which have shaped by philosophy of health education are justice and equality, self-esteem, education and learning, kindness and forgiveness, a higher spirit, helping others, family unity, goodness and morals, freedom and autonomy, self improvement, and self discipline. Undoubtedly there are other values that I hold in high regard, but lack of space limits an extensive list. Each of these values give me a foundation for my existence, and can be identified in my philosophical approach to health education.

My philosophy of health education also has been greatly influenced by other values such as: the literature of the profession, conferences I attended, involvement in professional associations, and most importantly, colleagues. Their teachings, writings and personalities reflect my existence as a health educator. In addition, my philosophy of health education has been influenced by the philosophies of many whom I respect and consider dear colleagues. A personal philosophy includes more than identified values. It also must include what people believe in, or in another perspective, what they stand for. In other words, it is all a health educator represents or communicates through their lifestyle, their teaching or professional involvement and commitment.

I believe health education offers an individual an invitation to be and become - to reaffirm the self and become committed to the development of individual potential through decision making and action. [Shirreffs, 1976] I am committed to the philosophy of existentialism as an approach to health education. Shirreffs [1976] states that, "the existential health educator sees his/her function as one of awakening learners to their own capacities and of providing opportunities for them to be responsible for their own learning opportunities and/or ignorance. The existential health educator provides opportunities in which each student can 'be' and 'become' in an atmosphere of freedom coupled with responsibilities. He/she helps stu-

dents to understand that each individual is ultimately responsible for what he/she becomes. We cannot force individuals to behave in ways conducive to attaining and maintaining wellness, but we can offer knowledge and promote awareness to individuals regarding responsibilities for health related behavior."

I believe the ultimate goal of health education is to provide learning experiences from which one can develop skills and knowledge to make informed decisions which will maintain or better their health, or the health of others. It is important that the health educator provide these experiences without being a dictator of moral behavior. On the other hand, it is my belief that too often health educators are neutral and end up sitting on the fence regarding critical issues. There are times when a health educator should take sides, especially when they stand for certain principles, values, and standards that he or she believes can make a difference in the health of individuals or communities. When this occurs, information must be communicated in a way that gives guidance to those making health decisions. This is especially true with young people who are confused regarding their own morals and values as they relate to their health.

I believe that health education must be more than dissemination of information. The existentialists believe that the health educator's interaction centers around the clients in assisting them in personal learning quests. [Youngs, 1992]. Health educators must provide the opportunity for individuals to act intelligently on their decisions. All too often health education exists in a vacuum. In other words opportunities to implement that which is learned is nonexistent. Environments must be established to serve as a vehicle to put into action choices to improve lifestyles. One without the other is incomplete.

I'm also a strong believer that health educators must provide a role model for their constituency. The statement that, "I can't hear what you're saying because of what I see," has no place in health

education. Those of us that are health educators must strive to maintain a level of wellness within our own limitations and indulge in personal lifestyles which foster good health.

I believe the study of behavioral psychology is a must in order to understand the nature of those we educate. The future of health education will go beyond presenting facts. All too often health education falls short of its objective and goals. This is because we have failed to consider the variables that contribute to unhealthy behavior such as poor self esteem, lack of internal locus of control, poor social skills, ect., that lead to undesirable behaviors. Furthermore, we have not examined the factors that contribute to the aforementioned variables such as one's spirit and purpose and meaning of life. As health educators, we must work within this element of human existence. We must cease addressing the behaviors that cause ill health and focus on the reasons for the behavior.

We also must become knowledgeable regarding resiliency which people have in overcoming adversities. The potential for prevention lies in understanding the reasons why some people are not damaged by deprivation (Rutter, cited in Werner, 1979). The resiliency model described by Richardson and others (1990) has great promise and must be a part of the practice of health education.

Much has been written and practiced, especially by Asians, regarding the connection between the mind and body. The concept of psychoneuroimmunlogy is an example of the improvement of one's health status as a result of positive thinking. This was demonstrated by Cousins (1979) in introducing the mind body connection to Western medicine in his book Anatomy of An Illness. I believe the future success of health education will depend on how well we adapt the science of human behavior to mental, physical, social and spiritual wellness.

In conclusion, I am content to reaffirm a simplified philosophy that I had over three decades ago. It is refreshing to realize that

after thirty-four years in the profession my original philosophy has not changed but has been strengthened and reinforced by new educational theories, medical advancements, and most importantly, new developments in human behavior. This confirms what I have always believed, that I am no smarter that I was as an entry level professional: however, I know I am much wiser as a result of my experiences and professional friendships with colleagues who have taught me by example and challenged by beliefs. Of special importance in the development of my thinking and beliefs have been my students who have diligently listened to me profess. It is through them that I've grown and learned to appreciate the reexamination of what I believe to be the truth. My students serve as my inspiration and love for teaching and the profession. Our future is in their hands. Their beliefs and values, their philosophies will shape the profession for decades to come.

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CHAPTER 2

Educating About Health

William B. Cissell, Ph.D., CHES

When reflecting on personally held principles that influence professional practice, a health education specialist generally realizes that these are the result of a combination of early learnings, essential professional preparation, and varied life experiences. The array of practice principles guiding a professional health educator reflect basic values initially learned through the family; reinforced and enhanced through instruction by school teachers, religious leaders, and dispensers of intelligence through other community institutions; molded under the guidance of one or more professional mentors; and polished by applications in early practice opportunities. These principles are threads that weave a pattern of guidance for practice decisions. The more notable threads can frequently be traced by the health education specialist to the individual who initially presented the idea and/or the circumstance or example that first provided the practical proof of its applicability.

Education Empowers

The idea that education provides individuals and groups with the means to understand information and utilize it to enhance their health status is shared by virtually all health education specialists. Most currently practicing health education specialists probably learned this while they were young children. Many may not recall exactly when they first heard the maxim, "Get all the education you can; nobody can take it away from you," but they recognize that it is

a message that the educated person is far more likely to possess the ability to manage life's many challenges than the uneducated person. This message is frequently reinforced or enhanced by numerous other statements made by respected parents, teachers, and mentors about the advantages of a sound education. This idea is internalized by the bulk of all who seek to perform well in an academic forum.

Applying the concept that education empowers to health-related information is often expressed first to most prospective health education specialists by a health teacher in junior high school, high school, or college. For some, they may hear this idea first expressed by a nurse, a dental hygienist or another health professional. Having already accepted the premise that education empowers, it generally is easy for the prospective health education specialist to recognize the feasibility of education about health empowering the previously uneducated or undereducated to maintain and/or improve their health status. A logical extension of this application leads to the principle that the responsible health education specialist seeks to be continually knowledgeable of the latest scientifically accurate health information and to present this information to others as quickly and as effectively as is feasible.

Health Education Avoids Coercion

Almost synonymous with the goal of educating about health is the intention of doing so without manipulation of the learner. The ultimate goal of health education is to provide the inadequately informed individual or group with scientifically accurate health information and allow the recipient(s) of this information to choose the manner(s) of response. Model health education specialists neither judge the individuals and groups on the basis of their health behaviors, nor do they employ strategies that limit freedom of choice on the parts of learners or members of a target population. This is a message that was repeated many times in the readings I was assigned

by faculty in the three health education degree programs I completed at Southern Illinois University at Carbondale (B.S. and Ph.D.) and the University of California at Los Angeles (M.S.P.H.). It also was repeated many times by the faculty and students during class discussions. Among some of the more noteworthy authors of the assigned readings were Delbert Oberteuffer, Clare Turner, Thomas D. Wood, Dorothy Nyswander, Ruth Grout, Lucy Morgan, Edward B. Johns, Howard Hoyman, Godfrey Hochbaum, Elena Sliepcevich, and Robert D. Russell. Among the faculty who assigned the readings and led or facilitated discussion in the classes were Robert D. Russell, Charles E. Richardson, Deward K. Grissom, and Edward B. Johns. The goal of avoiding coercion while practicing as a health education specialist has been expressed frequently in the professional literature that I have read and in many of the professional meetings in which I have participated during my career. In addition to my mentors, I have heard this goal emphasized by Helen Cleary, Peter A. Cortese, Lawrence W. Green, William Creswell, Jr., Marion Pollock, Marian Hamburg, Helen Ross, Mary K. Beyrer, Robert D. Patton, Ann Nolte, June Gorski, Marshall Kreuter, and Lloyd Kolbe. Two references in the literature that come readily to mind when reflecting on this issue are Green and Kreuter (1991) and Cleary, Kichen and Ensor (1985).

Community as the Center of Gravity

While many professional health educators had previously touted the efficacy of community organization strategies for assisting human populations in identifying their health needs and finding the means to meet them, Green and Kreuter (1991) coined the expression that seems to express this concept most cleverly. Focusing on health promotion, a process that overlaps health education in many of its applications, Green and Kreuter state:

> In the final analysis, the most effective and proper center of gravity for health promotion is the community. State and

national governments can formulate policies, provide leadership, allocate funding, and generate data for health promotion. At the other extreme, individuals can govern their own behavior and control the determinants of health up to a point, and should be allowed to do so.

But the decisions on priorities and strategies for social change affecting the more complicated lifestyle issues can best be made collectively as close as possible to the homes and workplaces of those affected. This principle assures that programs are relevant and appropriate to the people affected, and it offers greater opportunity for the people affected to be actively engaged in the planning process.

This is true for health education. The community is the optimal unit of focus for assessing health education needs and planning, implementing and evaluating health education programs.

Health Promotion as a Health Educator's Tool

The health education specialist has education about health as a paramount goal. Among the intervention strategies the health education specialist uses are those that are promotional. However, health education specialists should avoid confusion about the parameters of health education and health promotion. Health education and health promotion are not two names for the same thing. Health promotion can be viewed as promoting health through several interventions: advocacy, education, medicine, law, engineering, and marketing. Whereas education avoids manipulation, promotion frequently employs manipulative and coercive strategies. For example, the interaction between an individual and the environment may be manipulated by engineering as when a device is installed in an automobile that prevents an intoxicated person from successfully using the ignition to start the engine. This promotes increased automobile safety; it also removes from the individual the choice of behavior, operating

or not operating the automobile, within this environment.

Manipulation and coercion of an individual's behavior are often beneficial to the individual, the individual's family, and the community in which the individual resides, works, and/or recreates. Control over some behavior patterns should reside in a unit of society greater than the individual. Therefore, health promotion is a legitimate intervention process as long as it is not abused. Health education specialists can, in good conscience, collaborate with other professionals and community leaders in empowering a community to exert control over individual behaviors that pose major potential health risks to members of the community. An excellent example of this is contributing to a mass media campaign to increase awareness of the health risks related to environmental tobacco smoke in a public facility. In doing so, it is appropriate to emphasize the detrimental effects of breathing sidestream tobacco smoke that have been documented through research studies. Aside from the health promotion intervention processes, there are a number of other categories of intervention processes which health education specialists can use that can be limited in scope to conscious health-directed behavior. Among these are lecture, group discussion, distribution of information through media (pamphlets, books, tapes, compact discs, films, slides, telecommunications networks, computer assisted instruction, health-related expert systems, etc.), simulation/dramatization, guided research (individual or group), analysis of case studies, field trips, mentoring, and internships. If the health education specialist maintains a focus on the principle of empowering the learner, all of these processes can be used without compromising the principle of avoiding manipulation and coercion of health related behavior.

Codes of Ethics Can Guide Professional Decisions

Many individuals have virtually no need for a published code of ethics. They have internalized and accurately reflect in their ex-

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pressed thoughts and deeds the positive ethical standards pervasive in society and in their selected professions. However, there are many individuals who have difficulty expressing thoughts and behaving in ways that reflect positive ethical standards. The latter, and individuals seeking to assist them in efforts to identify and act upon positive ethical standards, can benefit from having published codes of ethics. Developers of the Society of (for) Public Health Education (SOPHE) recognized the value of helping "raise professional ethics and standard" for health educators as early as 1949 (Tyler, 1951). In his presidential address, Clare Turner, SOPHE's first president, spoke of the need to motivate positive ethical standards (Cissell, 1976). However, it was 1976 before SOPHE adopted a code of ethics. Subsequently, a joint committee of representatives from the Association for the Advancement of Health Education and SOPHE recommended that members of AAHE endorse and use the SOPHE Code of Ethics until an alternative had been developed. Currently, there is no single code of ethics or compendium of codes of ethics endorsed by all professional societies in which health education specialists hold membership or fellowship. This is a challenge for our profession as we enter the 21st century.

Common Terminology

While we do not have a common code of ethics, professional health educators do have a common terminology. In 1934, the Health Education Section of the American Physical Education Association developed the initial statement of terminology. Three subsequent reports on health education terminology were developed in 1950-51, 1962, and 1973 with support from the American Association for Health Physical Education and Recreation (AAHPER). In 1990, the Association for the Advancement of Health Education, and Association of the American Alliance for Health, Physical Education, Recreation and Dance, convened a joint committee of delegates of the pro-

fessional societies belonging to the Coalition of National Health Education Organizations (CNHEO) and a representative of the American Academy of Pediatrics to clarify new terms being used within the profession and new applications of terms previously used and defined (Joint Committee on Health Education Terminology, 1991). It produced a twelve page report that was published in the Journal of Health Education (1991) and is currently being distributed by the American Academy of Pediatrics and the professional societies represented by CNHEO.

Areas of Responsibility and Competencies

As with the code of ethics, a major goal of the Temporary Steering Committee that met in New York in 1949 and the members attending the formation meeting of SOPHE in St. Louis in 1950 was establishment and promulgation of standards (Tyler, 1951). As has been described in considerable detail by Wolle, Cleary, and Stone (1989), the National Task force on the Preparation and Practice of Health Educators (NTFPPHE) guided the role delineation process that established the seven areas of responsibility and related competencies of entry level health education specialists. These have been incorporated into a framework for professional preparation programs to develop competency-based curricula for entry level health education specialists and serve as the base for the test of competencies for certification purposes.

The NTFPPHE also established in 1988 the National Commission for Health Education Credentialing (NCHEC), which performs three major functions for health education specialists. It certifies the competence of health education specialists, promotes continuing professional development, and collaborates with institutions of higher education, professional societies, and other credentialing agencies to strengthen professional preparation of health education specialists. The NCHEC, professional societies to which health edu-

cation specialists belong, and professional preparation programs are currently collaborating in an unprecedented manner to develop, verify, and gain recognition for the competence of health education specialists.

Summary

For health education specialists that review developments over the past thirty years, which virtually spans my professional preparation and career, they recognize that our discipline has matured into a professional field. It entered the current decade with the indicators of an emerging profession that is moving at a vigorous rate of evolution. Health education specialists can reflect on strong early leaders who laid a solid foundation of basic principles of practice. These early leaders exhorted their peers and students to identify with education, to empower learners rather than coerce them, to focus health behavior change programs on community settings rather than blame the victim, to practice in accordance with a sound sense of professional ethics, to acquire an appropriate array of competencies and expand and maintain them through continuing professional development, and to participate in professional societies to assure that the profession continues to evolve at a pace that will keep it abreast of new social and technological developments.

Health education specialists can take confidence in contemporary professional leaders who have considerable vision and are dedicated to building upon the foundation laid by the early leaders. Current leaders of health education are influencing the policies of government agencies, voluntary health organizations, institutions of higher education, industries and businesses, hospitals and clinics, schools, and communities in ways that have immense impact on the education of the American population about health. Health education specialists have immense potential to fulfill the promise that the visionary leaders of the past saw for the profession they were establishing.

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CHAPTER 3

SOME GUIDING PRINCIPLES ON HEALTH AND HEALTH EDUCATION: A PHILOSOPHICAL STATEMENT

Charles R. Carroll, Ph.D.

Everything I ever needed to know about Health Education, or so I thought, I first learned at The Ohio State University. It was my good fortune to have enrolled in a teacher education course that emphasized the potential role of any secondary teacher to influence favorably the health-related knowledge, attitudes, and behaviors of students. This was a somewhat revolutionary concept for me — that the school could be a positive force in improving health status! Little did I realize at that time, when I was preparing to be a science educator, that thirty-five years later, I would have the opportunity to reflect on my "professional roots" that took hold quite by accident during a "golden age of health education" at Ohio State.

In so many ways, I owe my career to these energetic professionals: Drs. Mary Beyrer, Wesley Cushman, Robert Kaplan, Ann Nolte, the late Delbert Oberteuffer, Elena Sliepcevich, and Marian Solleder. They inspired me, challenged me, and encouraged me for more than three decades. Although I am not really a collective clone of my former professors and associates, my philosophy, theories, and methodologies of health education are derived from the aforementioned individuals who remain as the number one force that still influences me the most today in my professional endeavors.

Over time, in different teaching environments, and under differing circumstances, my concepts of health education and even health itself have changed somewhat. Perhaps the term, evolved, would

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more appropriately describe my altered perceptions of these basic concepts. And yet, these newer constructs do not deviate too far from my earlier, original beliefs and understandings of what I am, what I try to do, and why I do or do not do certain things in my role as a health educator at Ball State University.

For instance, health itself has been defined by the World Health Organization as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. Though useful, this definition of health is not absolute, because health itself means different things to different people. Some "healthologists" describe health as a multi-dimensional condition including not only physical, but mental, social, and even spiritual aspects, thus recognizing the holistic, unified view of each person. Others view health as a commodity, a state or condition of the human individual to be used in the pursuit of personal or social goals. Here, health is viewed as a means to some end, rather than as an end in itself.

While all of these definitions have merit, I have come to view health in terms of "here-and-now" well-being as well as past and future well-being. (1) As such, I now emphasize the changing nature of health and one's potential role in improving health status and in the prevention of disease. Accordingly, I define health as a process of continuous change throughout one's life cycle.

From the very beginning of human life until death, the human organism is confronted with numerous forces that influence growth, development, maturity, well-being, and eventual decline. These dynamic, interacting hereditary and environmental forces may be either favorable or unfavorable, yet they determine the level of well-being that any one person experiences at any one time. (2) Moreover, these interacting forces are continuous and bring about accommodations or adaptations within one's total self. Consequently, health may be perceived as an ever changing process involving various interactions and adaptive responses. In essence, health is the

ability to function both effectively and happily and as long as possible in a particular environment. (3) Now, this operational definition of health isn't too far removed from Oberteuffer and Beyrer's original, yet more succinct offering in which they defined health as ". . . the condition of the organism which measures the degree to which its aggregate powers are able to function." (4)

Having formulated a broad definition of health, I should now like to focus on some of my adventures and struggles in the process of health education — the attempt to help people apply what is known about health to their own lives. Initially, I would have described my undertakings as process-oriented, i.e., helping students make informed decisions about personal and social health concerns and motivating them to do so. It wasn't long, however, until I inherited or was asked to develop a number of topic-specific health courses. Overnight, I had become a subject matter specialist in human sexuality, substance abuse, consumer health, and more recently, thanatology. Despite my tendency to overwhelm some students with subject matter, I still try to function as an "educational bridge" between fact and fancy, between concept and misconception, and between research and its application. (5)

While I serve as a catalyst in decision making and clarification of ethical issues, I sometimes feel as if I am mainly a consultant on health-related matters. In fact, some of my best class sessions are spent in answering or commenting on a myriad of students' questions, not unlike Larry King's "Open Phone America" or Rush Limbaugh's "Open Line Friday." On such occasions, I make pertinent applications, indicate connections between topics and between personal behaviors and potential consequences of actions, analyze facts and theories, and build concepts.

One of my colleagues, Dr. Wayne A. Payne of Ball State University, believes that some health educators assume the role of "secular minister." I think such a label often describes my major

function in the classroom. It certainly beats the criticism of my harshest detractors who describe me as a benevolent "social engineer." In a sense, I nurture hope and resolve guilt. I disturb and shake people out of complacency; I raise consciousness and express outrage; I display concern and then raise more questions in genuine puzzlement. I have even cautioned students that those under the influence of alcohol and other drugs may engage in high-risk sexual behavior that could, in turn, result in death, especially if the HIV virus is transmitted and the infected person develops the Acquired Immune Deficiency Syndrome. In other words, sex "under the influence" can be deadly! Amen!

And now I should like to share with you four of the guiding principles that have helped me tremendously as I try to influence favorably the health-related knowledge, attitudes, and behaviors of college students during the last decade of the Twentieth Century.

Empowerment. Recently, I have become intrigued with the concept of personal empowerment in relation to health education. In my attempt to become more skill-oriented in my teaching objectives and to become more of an enabler for my students, I have begun to emphasize behaviors that can enhance health and to deemphasize factual trivia that serve mainly as convenient bases for test questions. Although this skill focus is not a new goal of health education, the concept of empowerment is revitalizing, more consciousness-raising, and much more socially focused than the traditional educational approaches that stress individualism and actions that may eventually trickle down to preordained behavior change and life-style program. (6)

Although ideally developed for community health advocacy, as noted by Miner and Ward (7), I can see the potential of empowerment as another means of "interpersonal" health education. As I view the concept, empowerment is an ongoing process of liberation, and maybe even one of democratization. It restores people's capac-

ity to act with others to improve the quality of life. As people experience and engage in the empowerment process, they have the potential to grow and change.

Sometimes, empowerment levels the so-called "playing field" between patients and physicians or other care-givers. Smart patients are now encouraged to communicate with their doctors so they, the consuming patients, can get better treatment or decide to select other health care providers. Indeed, the whole field of patients' rights, including "informed consent," seems to be based on the social empowerment model which may eventually lead to a newly structured health care delivery system that views physicians more as health care consultants and less as miracle-workers.

In my estimate, empowerment is also a potential remedy for the number one problem that is often cited as interfering with mutually satisfying and rewarding relationships, and the number one problem that is frequently at the very core of broken relationships, separations, and divorces. As you might have guessed, the problem is "poor communications" — a failure to speak-up, to express needs, to resolve conflict, to say "no" without hurting one's partner, to demonstrate care and appreciation, and to share. These empowering communication skills are not meant to develop power over one another. They are intended to facilitate interactions between partners in an on-going process of active listening and expression, a consciousness-raising challenge in promoting healthy sexuality. Perhaps the term, enablement, more accurately describes this function, but I like to think about ways I can empower my students to jointly resolve sexual harassment, driving under the influence of alcohol, and joining with others in a memorial society to arrange simple, dignified, and economical funeralization or body disposition after death.

Life-affirmation. When I inherited the death and dying course at Ball State University nearly twenty years ago, I adopted an operational principle that is best described as "life-affirmation" in

relation to the various topics of thanatology. I chose not to dwell on mortality. Rather, I have deliberately tried to emphasize the positive, life-enhancing aspects of death-related topics.

Through a variety of learning opportunities, I try to explain grief as a normal and desirable response to bereavement. In studying the meaning of death, I emphasize the importance of appreciating others while they are still here and while we still have time to share our thoughts and affection. In a study of the autopsy, I clarify how the dead can help the living via "gifting," and how a postmortem exam can establish an assessment of clinical medical practice as well as reveal genetic defects that could possibly affect the children of the deceased. And most importantly, in studying various psychological reactions often displayed by dying individuals, I propose ways of relating to the dying and helping the dying to live as fully as possible — often through inclusive activities and the promotion of decision making.

Interconnectedness. Regardless of subject matter or course title, I try to demonstrate the many interconnections that exist between and among the topics that are generally considered within the health science curriculum. In a study of alcohol and other drug problems, I emphasize the potential effects of drug use on college performance and drop-out rates as well as the influence of advertising on the mind-set of many Americans who believe firmly that one cannot have fun at a party without consuming alcoholic beverages. When the course deals with human sexuality, I also discuss the expenses of childbirthing, the selection of a marriage counselor or sex therapist, and the portrayal of sex roles in movies and television programs. Whenever the topic is weight control, cancer, cardiovascular health, or even mental health, there is always a need to evaluate news reports, radio and/or television guests, and newly released books that claim some novel remedy or recommended regimen. We must have some basic criteria by which to assess the latest cure or approach to health maintenance, especially when dealing with "alternative medi-

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cine." And when the topic is AIDS, I will focus not only on transmission of the HIV virus and specific prevention techniques, but also on the impact of this modern epidemic on the current health care system and on the psychological responses of the person with AIDS.

First introduced to the ideas of interconnectedness and conceptualization by analyzing the School Health Education Study (8) or SHES, I still try to demonstrate the linkages between many topical areas and prove that all health education is really consumer health education. The original SHES Study also made me more conscious of the comprehensive nature of the health curriculum and of the continuing need for establishing behavioralized teaching objectives to guide my classroom activities.

Admission of health education's limitations. It didn't take long for me to realize that health education does not have all the answers to personal or social health problems. Sometimes we recommend certain modes of action or life-styling changes that are quite impossible for our target audience to adopt, due to unavailability of resources or lack of accessibility to those resources. Increasingly, I even question my right to intrude on the privacy of others so they will more likely accept predetermined reforms of their health behaviors. As a health educator, I willingly admit that I do not have all the answers to promoting health and preventing disease. But that will not stop me from asking probing questions that disturb people out of their complacency.

There is yet another aspect of health education's limitation that I have begun to realize: the very best health education experience may not result in changed health-related behavior, if there is a lack of environmental supports, such as, health promoting legislative initiatives and governmental policies, engineering technology, and regulation of mass media advertising and business practices. With regard to alcohol abuse, I have become more aware of the epidemiology of alcohol problems as I learned that many local governments allow three or more liquor stores in the same city block. And in spite

of disclaimers from advertisers, it has become apparent to me that malt liquors are more heavily targeted to specific ethnic minorities, especially in inner cities. I am alarmed at the fact that many campus newspapers derive more than one-third of their revenues from alcoholic beverage ads. Alcohol abuse prevention remains a major challenge to health education.

Health education must now join with other environmental programs in an on-going effort to promote health and prevent disease. Health education alone cannot do the job!

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CHAPTER 4

PONDERING A PROFESSIONAL PHILOSOPHY

Judy C. Drolet, Ph.D., CHES, FASHA

To be a philosopher is not merely to have subtle thoughts, nor even to found a school, but so to love wisdom as to live, according to its dictates, a life of simplicity, independence, magnanimity, and trust.

—Henry David Thoreau

At several points in my professional development I have been asked to reflect on my philosophy of health education. Such an exercise demands defining those fundamental truths upon which other truths depend. This process of capturing dimensions, "colors", and visions might be compared to exploring the varied and complementary mosaics of a "kaleidoscope". Such an exploration requires examining what is health? What is education? What is health education? How has the nature of the learner changed, and how should the learning process be adapted to meet the needs of the learner? Like a good "learner", I, in turn, have asked my own students to consider the "who, what, when, where, and how" of their philosophies. The process remains a challenge...an essential contemplation that affirms much of what has come before and provides direction for what is yet to come.

Pondering principles, standards, definitions, theories, models, societal "moments", and literature is quite valuable in this process. Being at the right place at the right time...with the right

people...also provides essential guidance. These are familiar ingredients that can blend to create beliefs and goals for a professional lifetime.

TURNING THE KALEIDOSCOPE: IMAGES FROM THE PAST

So I turn the kaleidoscope...for before I can discuss a present and future, I must begin with a past. The wisdom of hindsight allows me to recognize even the earliest influences of my childhood. Growing up in San Francisco, I was blessed with parents who valued life-long learning, trust, discipline, respect, the pleasure of surprises, freedom, and humor. While being reminded not to take myself too seriously, they instilled respect for sincerity, dependability, responsibility, productivity, tolerance. I learned that it's not important to know everything; but helps to know where to look it up. I learned that worrying can be compared to sitting in a rocking chair: it keeps you very busy but doesn't get you very far. With this parental support (and 12 years of Catholic school) those sometimes "abstract" concepts became realities adding richness to the pieces of the kaleidoscope that are my life as "health educator." For although a philosophy can serve as a foundation for values, I see a reciprocal relationship of these fundamental values influencing philosophy.

This foundation drew me easily to a profession such as health education where issues, content and processes are relevant to us as "real people". Personal values influence what I think and feel and do in my chosen profession. Since this is true for each health educator, personal values also have great importance to the field of health education. We cannot offer "value free" health education. Our pasts and the values we acquire are integrally involved in all that we include and exclude from our offerings. Additionally, over 35 years ago Mayhew Derryberry reminded us that we "need to be constantly alert to the problems of concern to the people and to utilize all that is known about the way people react, think, and work." The challenge we must accept is recognizing values and including balanced educa-

tional experiences.

Recognizing the importance of past influences has remained inherent in my beliefs about health education. Gus Dalis told me once that he appreciated my being a traditionalist. As health education grows I believe that we have an obligation to respect and build upon the efforts and insights born of literally decades of investment (strong emotions; much time; many dollars) of those who conceived of and continue contributing to a vision for health education. This belief is not merely the cliche of learning from our history. When turning the kaleidoscope, eventually we do return to our original pattern before again moving on to a new one. We must instill the need for examining past lessons for insights that can be integrated into contemporary assessments and guide our future directions.

In each phase of my career "travels" I have been blessed with key mentors who offered guidance and opportunities. They served as human "bridges" in the evolution of my thinking and investment in our profession. I have learned that just as they had great influence on my life, so, too, do I influence the lives of those with whom I work.

My formal training originated at San Francisco State University with Hal Cornacchia's instruction about the conceptual approach of the School Health Education Study (SHES) of the 1960's. The value of this model was reinforced during my doctoral studies at the University of Oregon. Little did I know that two decades later I would expand my appreciation of the SHES lessons as a colleague of Elena Sliepcevich, Bob Russell and most of this landmark project's writing team.

SHES continues to be a fundamental framework for health education. Regardless of other occurrences locally or nationally, over time the three processes — growing and developing; decision-making; and interacting — remain unifying elements for health education. Recently when defending the value of including health education in our university's general education offerings I returned to the

original SHES document. Its chosen concepts ultimately were understood and accepted by faculty from diverse disciplines. The heritage of SHES remains a pillar for understanding the need for "school" health education even at the postsecondary level.

Another lesson from the past is derived from Dorothy Nyswander who reminded us: "We are the most borrowing profession in existence, perhaps. But out of these borrowed items we have brought about a fusion of theory, principles, and practice that makes sense when we work with people." Health education serves as its own model for multiplicity; for cultural competency; for cooperation and shared existence. Health educators in their settings should cultivate this inherent interdisciplinary nature by selecting strategies that allow students and clients to better understand and accept diversity and uniqueness. Further, there is strength in diversity. I believe that the values of most civil — or more accurately human — rights movements are inherent in our field. We have a responsibility to impact societal and global issues. Now, perhaps more that ever before, we should turn the kaleidoscope and focus on that which we have in common rather that our differences.

TURNING THE KALEIDOSCOPE: HEALTH EDUCATION NOW

These images from the past create a philosophy that guides present commitments and choices in practice, research, and programs. My greatest commitment has been to school health education. In school settings, health education should be offered in age-appropriate scope and sequence from initiation of formal education (pre-K) through secondary and postsecondary levels. All students should be provided content and skills that will allow them to apply their learning throughout a lifetime. Teachers, including elementary educators, should be professionally prepared in comprehensive school health models and offered ongoing training to remain current and challenged. Administrative support is essential to their success and

that of their students. Strong ties between professional preparation programs and staff in schools and other work settings should be established and cultivated. These alliances can result in reciprocal improvements in delivery of health education through diminished duplication, shared resources, and realistically addressed needs.

We must include parents and caregivers so that our messages are continually reinforced in informal settings. Guardians can be our best health education advocates. It is imperative that we become more aware of community standards and values. Coalitions have always produced stronger more positive results. Collaboration among school staff; teachers and parents; faculty in higher education institutions; personnel in community agencies and schools will enhance the likelihood of institutionalization of health education in our education systems and adoption of positive health approaches by those whom we educate.

We also need to include the students! Models such as Teach Us What We Want To Know and Students Speak are classic reminders that we should ask students about their own needs rather than assuming that we know.

Teaching It's often said that we teach as we are taught. If this is the case, my mentors/models helped me learn to: be interested in each individual; use strategies that help students personalize information, theories, research and skills; expand application of individual health education to broader global issues and concerns. I learned the need to "walk your talk" and have the courage of your convictions. I came to understand that healthy children learn better. Healthy people work better. Healthy families interact better. Healthy people function better within society. I came to believe that, regardless of work setting, we are all teachers. And we do touch the future. Not unlike the image of ripples from a pebble dropped in the water, we don't always see where the impact ends.

Teaching a solid core of factual knowledge about current health issues is essential. We must become and remain knowledge-

able about the content base of our field and current thinking from all disciplines that influences it.

But we've come to understand that having content alone does not impact on health-related attitudes and practices. Health educators must truly recognize the importance of interpersonal skills. Health education can provide a forum that allows people to develop interpersonal skills as they relate to health issues. We must provide exposure to personal and social skills and opportunities to "practice" them. Then, when the moment is right, our students (in the broadest sense of the word) will have this foundation upon which to draw as they respond to life's daily issues.

My experience as a former English Literature major provokes also approaching "skills" from a different direction. Ability to communicate through strong verbal and written skills should permeate all dimensions of health education. Health educators should develop their abilities by exploring educational options in complementary disciplines such as marketing, speech and mass media communications.

Another "skill" that health educators may strive to attain is "comfort" dealing with controversial topics. When working in some content areas of health education, discussion about becoming "comfortable" with subject matter inevitably occurs. Particularly with taboos of our society such as those addressed in sexuality education and death education, perhaps comfort is not a reasonable expectation. More importantly, awareness of the basis of our discomfort and focus on including balanced offerings should be our goal. Self-examination of personal beliefs and values is a necessity. By helping students and clients identify personal limitations and appropriate resources, health educators can contribute to formally addressing - perhaps for the first time - these inevitable experiences of our lives.

Yet another "skill" may involve conflict management. Because we frequently deal with subjects previously omitted from formal education, classroom or workshop health education discussions

should provide open forums to talk freely. Parts of our world, nation, neighborhoods are dominated by anger, fear, hatred, violence and destruction. With appropriately identified ground rules, health educators can address and value each person as an individual. For some with whom we work, we may provide literally the only vehicles they access for confronting intolerance, stereotypes, biases and the unknown. When we "put a face" to those who are "different", suspicions and fears are diminished. Our health education experiences may be the first time our students and clients are asked to consider how and why they feel and act the ways that they do.

How do we prioritize these myriad "skills" in daily practice? Upon entering higher education I was confronted with dichotomous beliefs among colleagues and administrators about establishing a professional "agenda." Although encouraged to identify a specific focus for teaching and research, the majority of my early career was spent as a "generalist". The courses I taught and a variety of research interests allowed exploration of the spectrum of health-related processes and content areas. I respect those with in-depth expertise in one or two areas yet still believe in the value and versatility of a broad-based foundation. The complex nature of health education creates a need for this type of health educator. Further, teaching an array of content area courses is a reality in secondary schools in response to categorical funding and in many higher education departments.

Only in recent years have I narrowed my focus to three primary areas: (1) mental health - I strongly agree with Murray Vincent in his AAHE Scholar Address in 1991 that we need much more emphasis on the affective dimensions of health education. (2) sexuality education: I affirm Sol Gordon's work...and believe that Bill Yarber's AAHE Scholar Address in 1992 is a "classic" contribution. (3) professional preparation: I remain convinced that we need expanded examination and greater priority for this critical aspect of health education. Now is the time to determine the current status and future

directions of professional preparation. Among our most urgent challenges and opportunities for influencing the future of health education is knowing if those doing the preparing are current and offering the content and skills needed in health education work settings.

Research Research and evaluation, particularly when theortical foundations of health education are addressed, remain important barometers of direction to the field of health education. But two caveats are warranted. First, research priorities should not be used to narrow health education practice. Besides physical behavior, we must remember that "health" by nature is multidimensional (mental, social, spiritual, environmental, and so on) as emphasized by the World Health Organization over 30 years ago. If we only focus on behavior, we limit ourselves to a disease prevention model. When we only measure behavioral outcomes, we exclude mental/emotional health, wellness, health promotion and other dimensions that are cornerstones of health education.

Second, researchers must be careful to build partnerships by communication with those in the field. My scholarly activities/publications frequently involve dialogues with practitioners. Teaching strategies, personal perspectives, and translating research for practical application are essential additions to professional literature. In turn, postsecondary (especially graduate) students can learn to continue the legacy. The mission, thus, becomes building teams by recognizing what we have received and giving it to others.

Service Higher education places clear value on teaching and scholarly productivity. Yet the service component often provides visibility for programs and, perhaps, contributes the most to advancing the profession. Ironically, too often these contributions go without formal acknowledgment. This lack of recognition in academia also can apply to other work settings. Yet we frequently "know" health educators for their leadership in associations; their participation in meetings; their service contributions.

Consider how we would exist without the volunteer profes-

sional service efforts of hundreds throughout this country and internationally. Through service health educators govern and maintain at least five major associations, an academic honorary, countless committees, innumerable documents. Professional service is a "mirror" that reflects and a "window" that offers us a view of health education. Among the most prominent examples was the first ten years of role delineation. Our profession needed a formal means of identifying who we are and what we do in practice among our work settings. The process to national individual certification was arduous but ultimately fruitful for those involved. I believe that these efforts at defining and implementing mechanisms for "certified health education specialists" (CHES) epitomize the contributions of true leaders capable of increasing the speed at which we turn the pages of history.

TURNING THE KALEIDOSCOPE: FUTURE IMAGES

Now, as I'm nearing two decades in our profession, I find myself experiencing yet another turn of the kaleidoscope. As always, a blend of past and present create the vision for the future. Oliver Wendell Holmes said "I find the great thing in this world is not so much where we stand as in what direction we are moving." I suggest that we must maintain a vigilant watch over that which we have created and the directions we are moving. I am concerned that we still experience identity crises both within and beyond our profession.

At times we still "talk to ourselves" too much and not enough to others. We must advocate for health education at the local level to ensure better educational outcomes. We must infuse a passion for establishing a recognizable visible presence among educational disciplines as much as within health care reform. We must cultivate our political activism. We have yet to speak with a unified voice. Yet we must learn how to market ourselves and our work; and learn how best to professionally prepare for this expanded status. Further, in the current climate of budget restrictions and program restructuring,

examination of the status and future of health education doctoral programs is needed.

Dorothy Nyswander challenges that "Tomorrow will be more difficult than yesterday....Do we look backward for precedents to follow or do we look inwardly at the self..." We must participate in responsible quantitative and qualitative evaluations of our work in all settings and showcase our best results. We need a healthy blend of statistics along with those values and standards learned in my earliest years. And we need more poetry!

A traditional African song says "the higher you build your barrier, the taller I become." We must build but also use what we already know rather than re-inventing the wheel. We must not become complacent but rather continue to grow. Health education has passed adolescence and moved into the challenges of early adulthood with broader responsibilities and obligations. We are forced to make decisions about priorities and directions. John D. Rockefeller, Jr. suggests "...that every right implies a responsibility; every opportunity, an obligation; every possession, a duty."

It seems that every day in health education I learn more than I teach. I believe that as health educators we have the privilege of working in a field that on a daily basis is creative, challenging and changing...that thrives on our passions and is cultivated by our dreams and visions. We can be "of" a profession that potentially elicits self-respect and pride, and encourages achievement of full human potential among our students, clients, patients, co-workers...and ourselves. As health educators we have an obligation to nurture and attend to our profession.

As I turn my kaleidoscope, I believe that our greatest hope comes once again from the caliber and talents of people we call "health educator". They comprise our past, and present; and offer thoughts, skills and hope for overcoming obstacles and facilitating a positive future for our profession. I believe through health education each individual can make a difference. Through the "work of our hands"

we see it over and over again. Consider what those hands united might accomplish.

Lastly, I believe in these "borrowed" TWELVE THINGS TO REMEMBER:

1. The value of time
2. The success of perseverance
3. The pleasure of working
4. The dignity of simplicity
5. The worth of character
6. The power of kindness
7. The influence of example
8. The obligation of duty
9. The wisdom of economy
10. The virtue of patience
11. The improvement of talent
12. The joy of originating

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CHAPTER 5

THE ROLE OF HEALTH EDUCATION IN WORKSITE HEALTH PROMOTION

James M. Eddy, D.Ed.

Worksite health promotion and disease prevention efforts have increased in number and sophistication over the past several decades. From my perspective, health educators can and should play a significant role in worksite health promotion and disease prevention. In this paper, I will outline five reasons why health educators should be integrally involved in the worksite health promotion and disease prevention movement.

Genesis of My Beliefs

In the early 1980's I saw the potential for health educators in worksite settings. At that time many health promotion professionals in worksite settings tended to have exercise science or medical training. These programs generally reflected the professional preparation bias of the worksite manager. Clearly, there was a need for health professionals with a more comprehensive and primary prevention approach to health promotion and disease prevention in worksite settings. This need could be easily met by properly trained health educators.

In order to train and place health educators in worksites, I along with Richard St. Pierre, Chair of the Health Education Department at Penn State, developed undergraduate and graduate level programs in worksite health enhancement. To insure that this program met the needs of companies in our targeted service area, we developed a Worksite Health Enhancement Program Advisory Commit-

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tee. This Committee included representatives from companies such as Westinghouse, Campbells' Soup, Champion International Corporation and Rohm and Haas. This group of health promotion professionals provided insights on trends and perspectives in worksite health promotion.

A key component of the Worksite Health Enhancement Program at Penn State was the internship experience. As the numbers of students in the program increased, so did the need for internship sites and subsequent supervision. Consequently, I was able to visit well over 50 corporate based health promotion and disease prevention programs. At each of these visits, I carefully assessed what worked and what didn't work and the extent and how each company's worksite health promotion program was integrated into the fabric of the organization.

In addition, over the past ten years I have attended and presented at numerous health promotion professional meetings focusing primarily or exclusively on worksite health issues. These meetings brought together professionals from health education, medicine, exercise science, marketing, organizational development, public health, psychology, and nutrition. The common thread was the site of implementation...the worksite. Participation in these professional meetings provided insights on the nature and scope of the health promotion and disease prevention movement. As well, I was able to glean from the presenter and participants how they systematically approached health promotion and disease prevention issues and concerns.

Throughout these varied of experiences, I was struck by the clear and vital role health education could play in the worksite health promotion movement. I was convinced that the underlying tenets of health education, if properly introduced into worksite health promotion and disease prevention programs, could significantly enhance the state of the art.

Therefore, I have spent most of the past ten years of my pro-

fessional life working to demonstrate the important role health education plays in worksite health promotion. This paper will outline five interrelated characteristics of health education that highlight relevance to worksite health promotion and disease prevention programs.

1. Classic Definitions of Health Education and Health Promotion Have Clear Relevance to Worksite Programs

Green's definitions of health education and health promotion have clear relevance to worksite health promotion programs. These definitions are:

> *Health Education* - "Any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health" (Green 1980)
> *Health Promotion* - "Health education and related organizational, economic, and environmental supports conducive to health" (Green 1984)

The goal of many worksite health promotion programs is behavior change. Green's definition clearly reflects this behavioral emphasis. In addition, because many programs are voluntary (especially in light of the new ADA requirements), Green's definition of health education has added significance.

Effective worksite health promotion programs tend to be those programs that are clearly integrated into the organization and include social support and policy components. For example, traditional educational programs designed to enhance employee knowledge of the need to use safety belts and refrain from smoking have yielded marginal success. The success rates for such programs increase when appropriate organizational policies are also implemented and social support interventions (e.g. smoking support groups, peer pressure to use safety belts, etc.) are added. Clearly, these definitions of health education and health promotion commonly accepted in health education would have implications for worksites and would significantly

enhance many worksite programs if systematically integrated into the corporate organization.

2. The Applied Nature of Health Education has Relevance for Worksites

Health education draws upon many disciplines for its cognate base. Similarly worksite health promotion programs draw from many fields including business, psychology, marketing, health, medicine, social science, and exercise science. Generally, worksite health promotion and disease prevention programs tend to take the form of the professional preparation of the management. Therefore programs directed by exercise professionals tend to focus on exercise behavior and programs directed by nurses on early intervention and secondary prevention components. Although these program components are needed in a comprehensive health promotion intervention, programs with such narrow foci tend to omit or disenfranchise a large percent of the target population.

Because health education, by its nature, tends to draw upon a variety of disciplines, the health educator is more likely to propose programs that are more comprehensive in nature, inclusive, and include both primary and secondary prevention components. The skills learned in this synthesis process can be easily applied to worksite health promotion and disease prevention programs. Successful worksite health promotion programs draw upon and interact with various units within the organization such as employee benefits, corporate communication, safety and health, employee relations and corporate medical. The ability of health educators to work with and draw together the expertise and resources of other groups is vital to the success of worksite health promotion programs.

3. The Ability to Design, Implement and Evaluate Programs to Foster Behavior Conductive to Health are Key Competencies for Health Educators and are

Applicable to Worksites

Many worksite health promotion specialists with the training in a narrow field have excellent content knowledge in their professional area but have limited skills in the design of program interventions for a diverse population. Traditionally, professional preparation in health education programs has stressed skills to design programs to meet the needs and interests of the target audience. These skills can be easily applied in the worksite health promotion and disease prevention programs. Program development skills are enhanced by the health educators ability to draw upon various disciplines in the planning process.

In addition, many health educators, especially those with graduate training, have the knowledge and skills in program and outcome evaluation. Health professionals with these evaluation skills often realize the need to integrate evaluation concepts into the planning process and to insure that a clear articulation exists between program goals, implementation strategies and program outcomes. Such skills are vital to the success of worksite health promotion and disease prevention programs.

4. The Needs and Interests of the Target Audience is a Key Concern in Planning Health Education Programs in All Settings

Inherent in the contemporary health education planning process is a sensitivity to designing programs that meet the problems, needs and interests of the target population. As an undergraduate student majoring in Health Education at the State University of New York at Brockport, my Professor for program design and curriculum development, Dr. William H. Zimmerli, constantly stressed the need to know your target audience and to insure that your programs met their needs and interests. Today, most all program design models address the need to know your target audience and to develop programs to meet the benefits they desire from health promotion.

This notion is especially valid in worksite health promotion and disease prevention programs today. Worksite health promotion conferences are replete with program sessions on marketing. Most of these sessions address theories and skills to identify the needs and interest of a target population and then to develop programs to meet those needs. The concepts and skills discussed often closely parallel the basic tenets of most health education program planning models. Therefore, I firmly believe that health professionals should use health education planning in the design, implementation and evaluation of worksite health promotion and disease prevention programs.

5. Principles of Evaluation in Health Education are Applicable to Worksite Health Promotion and Disease Prevention Programs

In worksite health promotion and disease prevention programs often great promises are offered with little more than anecdotal evidence to support program success. Worksite health promotion and disease prevention programs could benefit from including formative, process, behavior change and cost effectiveness modes of evaluation (Eddy, Gold, Zimmerli, 1990). Most professional preparation programs in health education, especially those at the graduate level, provide students with these evaluation skills. It is my opinion that for health promotion and disease prevention programs to flourish in worksite settings, key personnel must be able to systematically and comprehensively evaluate programs.

To iterate, health educators also have the knowledge and skills to weave evaluation activities into the planning process and program implementation activities. These skills are important for two reasons. First, these evaluation components insure that program objectives articulate with the actual program activities and outcome measures. And second, the process insures that appropriate baseline data have been collected in order to adequately measure change.

Closing Remarks

Health Educators have many skills and competencies that can enhance the state of the art of worksite health promotion and disease prevention programs. It is incumbent upon health educators to learn how to work within the corporate organizational structure to integrate health education theory and practice into worksite health promotion and disease prevention programs. In essence, health educators need to initially learn how decisions are made and policies implemented in worksite settings and then work to integrate health education concepts and principles into the organization. Attention to these points can help to better integrate the health educator into worksite health promotion and disease prevention programs.

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CHAPTER 6

HEALTH EDUCATION: BUILDING PROFESSIONAL BRIDGES TO SPAN THE DECADES

Nancy T. Ellis, HSD, MPH, CHES

It is a pleasure to participate in this endeavor to personally reflect upon past events in the health education profession as well as to project future needed initiatives. Being in the profession over two decades has afforded this author the opportunity to witness significant strides in health education and related professional preparation. As health educators, we are living in exciting times. If only, collectively, we capitalize on past contributions as well as create and seize present and future opportunities, what accomplishments await our profession unbeknownst to us even today! From whence our profession has come and henceforth its future direction depends upon our foundation and how we span our efforts and bridge our differences.

The health education profession, metaphorically, is analogous to the purpose and design of a bridge. A bridge is a structure that spans obstacles, such as rivers and valleys, to provide a roadway (The Encyclopedia Americana, 1989). Likewise, health education is a professional infrastructure dedicated to overcoming obstacles (preventable morbidity and mortality) to provide a roadway to quality life here in the United States and worldwide. Historically, professional preparation in health education parallels the evolution of bridges from very simple to potentially magnificent, complex structures.

Reminiscence: Early Bridges

The first bridges were constructed with limited tools and building skills, thus necessitating use of materials that required a minimum of forming and shaping. The earliest and simplest bridge de-

sign was one or more rigid logs or beams laid across a stream so that the two ends rested on opposite banks (The Encyclopedia Americana, 1989). In essence, the foundations were at the sides.

Early and even current leaders in health education (human foundation for health education) came from assorted "side" related professions as well: medicine, nursing, physical education, biology, education, and psychology among others. These early leaders had no initial health education preparation, but were persons of vision responding to unmet health needs. Thirty-seven such individuals were honored in The Eta Sigma Gamma Monograph, "Key Leaders in Health Education: A Century of Commitment" (1990). This is a historical document for our profession. Yet, there are so many untold stories each of us practicing health educators can recite that have profoundly influenced our professional careers and lives. Hundreds of both recognized and unrecognized health educators knowingly or unknowingly touched someone's life professionally and made a difference. Such individuals laid a foundation for future health education practitioners. Individuals like J. Keogh Rash (Indiana University), and Warren Schaller (Ball State University), Donald Ludwig (Indiana University), and Virginia Huffman (West Chester University) exemplified guiding principles for professional preparation settings that remain with this author to date. Such standards include:

1. the value of students as a major commitment
2. availability to students and respective colleagues
3. attendance at student activities and Eta Sigma Gamma functions
4. encouragement and transportation for students to attend health conferences
5. the commitment to classroom instruction
6. never discouraging but rather motivating an individual to pursue his or her idea
7. a willingness to verbalize and role model dimensions of health

8. encouragement to pursue a higher education or degree in health
9. modeling a team approach and sharing among colleagues

Fortunately, for women contemplating and entering the health education profession, there have been caring, influential and highly competent female role models known through their research, classroom instruction, professional presentations and service, authorships and personal interaction with aspiring young professionals. Mary K. Beyrer, Ann Nolte, Elizabeth Neilson, Elena Sliepcevich and Elaine Vitello, among others have planted a second generation of women professionals to succeed them.

There have been two books influential in shaping this writer's beliefs and actions about health and health education, the first being biblical scriptures addressing physical and spiritual well-being (Thompson Chair Reference Bible, 1984). Secondly, J. Keogh Rash's course manual, The Health Education Curriculum, later to become a textbook with Morgan Pigg, profoundly influenced this author's professional, administrative and teaching philosophies as a school health education coordinator and university professor. For schools unable to afford commercially prepared health curricula and for communities desiring to develop, test and implement their own curricula, this text is as appropriate and applicable today as was its original basis over two decades ago. Significant concepts emphasized included the symmetrical, multi-dimensional nature of health; "intelligent self direction of health behavior;" health being a crown on a well man's head, but visible only to the sick man; features unique and common to school and community health programs and bridging their gap; the cooperative approach in health education; curricular planning criteria of needs, interests, comprehension ability, dependency and developmental issues, and community values; expected outcomes of practices, attitudes and knowledge among other noted principles of

curriculum development. Throughout the decades, numerous other individual scholars, publications and organizations, served as simple but strong bridges to move our discipline toward a profession.

Spanning Greater Distances in Health Education: Suspension Bridges

Suspension bridges can span even longer distances than rigid beam constructions. The supporting members of a suspension bridge are continuous flexible cables with each cable anchored at both of its ends. A level roadway is suspended below by stringing cables overhead on high towers (The Encyclopedia Americana, 1989). Not unlike the suspension bridge, greater bridges were built to strengthen and support the road for health education. During the latter two decades of this author's career, significant events occurred demonstrating flexibility and unity (continuous cables anchored to firm foundations) for advancing the health education profession. Just entering graduate school in health education, this author was impacted by the founding of The Coalition of National Health Organizations in 1971 with a goal to mobilize the resources of health education in order to expand and improve the profession. A major purpose was to facilitate national-level communication, collaboration and coordination among member organizations (Rubinson & Wesley, 1984 & Cauffman, 1982). Also significant was the establishment of the National Center for Health Education. This Center later, in 1978, initially funded the Role Delineation Project for Health Education.

Within 10 years, and as a young professional, this author witnessed trying and monumental efforts (similar to difficulties of designing and constructing a suspension bridge) to advance the profession from the Invitational Workshop on Commonalities and Differences in the Preparation and Practice of Health Educators (1978) to the refinement of "A Framework for the Development of Competency Based Curricula for Entry Level Health Educators" (1983) to the establishment of the National Commission for Health Education Credentialing (1988) (National Commission for Health Education

Credentialing, 1991). This Commission oversees individual certification in health education. Indeed the profession had spanned great distances in just one decade. But to become complacent would mean professional stagnation. The future also is ready for harvest!

Future Initiatives for Health Education: Arched Bridges

The arched bridge is in a sense the opposite of a suspension cable bridge. The suspension cable tends to pull its anchored foundations inward necessitating the cables to withstand stretching. However, the arched bridge supports itself by meeting at the top, center of the curve where its own collective compression at the top and against the sides hold the structure in place (The Encyclopedia Americana, 1989).

Similar to the arched bridge, health education professionals and organizations must collectively apply positive force, centrally and in the same directions. While the opportunity to address current and future health issues is limitless, caution should be exercised not to dilute our potential. Timely and strategic planning is essential. For example, recently in June, 1992 a historic event occurred in Phoenix, Arizona. With the leadership and support from John Seffrin and the American Cancer Society, 100 professionals representing over 40 national health, education, and social service organizations and agencies met to develop a National Action Plan for Comprehensive School Health Education (American Cancer Society, 1992). This concentrated effort was a response to the changing epidemiological health profile of our nation's children in the last 40 years which necessitated a reassessment and new initiative for intervention.

Similar short and long term collaborative efforts must address carefully thought out and delineated issues and provide recommendations and action plans to bring meaningful resolution. Future credibility of the health education profession rests on these three issues: (1) Keeping abreast with state of the art technology, (2) addressing needs of diverse and disadvantaged populations, and (3) marketing and advocating health education.

State of the art technology. The health education profession must remain abreast with educational and worksite health related technology. The potential of microcomputers and related software is unlimited. Microcomputers enhance communications, instructional strategies, health assessments, research design and management, and access to data bases (Gold, 1991 & Breckon, 1986). Furthermore, technology for distance education allows educational institutions and public agencies to reach nontraditional students and less accessible target populations.

Special populations. By the year 2000, the social and ethnic composition of the American population will form a different profile. Whites, excluding Hispanic Americans, will represent a smaller proportion of the total while Hispanics, Blacks and other social groups will increase. Additionally one third of the nations poor are found within only 12 percent of its population, which is black. Also, by the year 2000, people over age 65 will have increased to about 13 percent of the population in contrast to 8 percent in 1950 (U.S. Department of Health and Human Services, 1991).

Given the ethnic, racial, socioeconomic and age-related demographics of our country, the health education profession can no longer afford to give lip service (publications and reports) to this challenging issue. There must be increased awareness, sensitivity and action-based response to genetic, socioeconomic, cultural and age related health risk factors and intervention approaches.

Health education professional preparation programs in colleges and universities must better attract, recruit, and retain majors from disadvantaged and culturally diverse populations who subsequently as professionals will possess a greater indepth understanding of special population needs and can serve as positive role models and program advocates.

Cultural diversity, should be evident in course syllabi of every professional preparation course. A separate offering should be made available on multicultural education as it impacts health edu-

cation and health programming (Pahnas, 1991). This author firmly supports that the document, A Framework for the Development of Competency Based-Curricula for Entry Level Health Educators (National Task Force on the Preparation and Practice of Health Educators, 1985) should directly address multicultural subcompetencies and objectives. Furthermore, professional preparation programs which are accredited should ensure that a major criterion be evidence of curricular and pedagogical emphasis on multiculturalism and special populations. Professional ethics should also be inherent throughout the curriculum.

Marketing of, and political advocacy for, health education. The future of our profession lies with health educators, individually and collectively, becoming proactive. Self validation and promotion within our professional circle is not enough to warrant public confidence. Health educators must be accountable for tax dollars spent and provide to the public credibility of our product (primary and secondary prevention). There is abundance of evidence supporting health education based upon vital health statistics and innumerable needs assessments. What is needed, however, are greater quantity and quality of well designed, qualitative and database research that documents health education does work. The health educator's role as a researcher is paramount to the credibility of our profession. Armed with this kind of impact data and scholarship, health educators are better able to make a case for advocacy to administrators, legislators and the public in general. Documented results also better facilitate funding for future research and program initiatives. Helpful to this endeavor is the Eta Sigma Gamma Monograph, Making Connections in Health Education Research and Practice (1991).

Health educators can no longer afford to await public identity, but must individually come together for a unifying mission to market the competency and value of our profession via political advocacy (Taub, 1985). "It is increasingly obvious that isolated attempts to solve a problem are not effective; the team approach should

be our aim" (National School Boards Association, 1991-2). Individual health educators and national professional health education organizations need to advance lobbying efforts and strategies aimed at local, state and national public officials to represent our vested interests and those of our communities and nation.

Final Observation and Hope for the Future

In retrospect, this author is in awe of, and has high regard for, the young professionals graduating from our health science professional preparation programs today. Many are recipients of two or more health related degrees and certified through a credentialing process. They are better equipped with knowledge and pedagogical, research, advanced techniques and technical skills than ever before in the history of our profession. Capitalizing on past professional bridges, the challenges these young professions pursue, and the accomplishments they offer will undoubtedly bring further impetus to the health education profession in meeting society's needs. The future of our profession is in good hands!

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CHAPTER 7

HEALTH EDUCATION: A SMORGASBORD OF LIFE

Joyce V. Fetro, Ph.D., CHES

I believe that children are our future.
Teach them well and let them lead the way.
Show them all the beauty they possess inside.
Give them a sense of pride.
To make it easier.
Let the children's laughter
Remind us how we used to be...

—Michael Masser and Linda Creed
(Lyrics from The Greatest Love of All)

When I was 35 years old, I quit smoking cigarettes. I began smoking when I was a 19 year-old university student. During the subsequent 16 years, I smoked anywhere from 10-25 cigarettes a day and quit on several occasions -- once for almost two years.

As far as I can remember, I have always known that cigarette smoking was harmful to my health. I was aware of the risk of lung cancer. I had seen lung tissue — blackened and destroyed by pollutants found in cigarette smoke. I met someone with an advanced case of emphysema caused by cigarette smoking.

So, how did I, as a knowledgeable adult and health educator, process this information. No one in my family had ever died of lung cancer. My father, who smoked more than a pack of cigarettes a day since he was 17 years old, was living testimony that heavy cigarette smoking didn't always lead to lung cancer or emphysema. No one in

my family was diagnosed with high blood pressure. In fact, since my blood pressure bordered on low, I often joked about how smoking kept my blood pressure within normal range.

Like many before me, I tried to find any and every way I could to deny that I was doing something that might eventually decrease my life expectancy and affect the quality of my life. In my efforts to quit, I read a variety of self-help books. I became aware of key strategies, skills, and support systems I needed to reach my goal. And yet, I still could not quit.

One day while reading, I became aware of one key piece of information. That is, carbon monoxide from cigarette smoke upsets the chemical activity of cells in the inner lining of the coronary arteries, trigerring the build-up of cholesterol — the leading cause of coronary heart disease. This piece of information I could personalize. (At age 49, my father had triple by-pass surgery for coronary heart disease. And, at the young age of 59, he died of a heart attack.)

But more importantly, I was at a point in my life when I was ready to change my behavior, to use the information and skills that I had previously acquired. I am happy to disclose that my body has been "first-hand" smoke-free for nine years.

Some advocates of health education would emphatically state that its purpose is to change behavior. That we, as health educators, are behavior change agents. And, that the success of health education programs should be measured by monitoring changes in individual health-risk behaviors. If health educators were basing their success on my behavior change, however, they would have considered themselves failures many years ago.

This personal experience directly relates to my philosophy about health and health education. Many models have been put forth in an attempt to define health. Health has been described as a status...a continuum...a triangle...a multi-dimensional cube...a whole...a sum of many parts...and so on. Health may seem to be a phantasmagoria

of geometry. But regardless of the configuration, it is clear that health is multi-dimensional and that discussions about health is multi-dimensional and that discussions about health must consider all its dimensions — the physical, emotional, social, psychological and spiritual aspects.

Each individual conceptualizes a model of health consistent with his or her own personal experiences, attitudes, beliefs, goals, and aspirations — at a particular time, in a particular place, for a particular reason. How does one adopt a conceptual model congruent with his or her own philosophy? Maybe this goal is neither possible nor realistic.

For me, today, health may be one side of a triangle, attached to three facets of a cube, balanced on a continuum and rotating in space. Tomorrow, who knows? I may experience something tomorrow that could change my perspective on health or change my personal priorities. With that new experience, my model of optimal health would adapt based on my needs and concerns. But most importantly, my model would change because I chose to change it.

Some of my colleagues might say that this design is disordered, deranged, anomalous, meaningless, and just plain "wishy washy." That's just the point! To me, health has no defined configuration, no universal definition, but rather, as described so clearly more than 25 years ago in the School Health Education Study (1967), health is "a quality of life." That quality must be defined by the individual as he or she is growing and developing, interacting, and making decisions about health issues.

Today, more than ever, young people are finding themselves in situations where they must make choices that could have long-range effects on their health and well-being. Many are ill-equipped to handle these situations. Health education is the most obvious forum for targeting health issues and risk behaviors.

I believe that health education is an "ongoing process" — meaning that something is "going on." It implies continuous move-

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ment. The content and process of health education should change as individuals and current health issues change. To me, health education is an invitation to a smorgasbord. Health educators make the curriculum and program selections, arrange them in a way that is most meaningful and appealing to their students, and replenish them as needed based on several factors.

Individual Preferences: What are the current needs, interests, worries, and concerns of today's young people? Students have a right to be involved in making smorgasbord selections. As pointed out in previous student surveys (e.g., Teach us what we want to know, Byler, Lewis, & Totman, 1969; Students speak, Trucano, 1984), health educators sometimes make assumptions about health education program content without considering those who actually will be receiving the program content without considering those who actually will be receiving the program. Determining what students already know and what they don't know should guide not only the smorgasbord selections but how the main course will be presented. Informal surveys and/or discussions among students can identify critical health-related issues and concerns as well as take into account differences in students' learning styles, cultural backgrounds, and levels of understanding.

Recommended Dietary Allowances: What are the current health-related problems and issues? Traditionally, health education has been divided into ten health content areas (Association for the Advancement of Health Education, 1991). But, how much of each of these health education "food groups" is necessary? And at which grade levels? The range of topics and issues and the amount of detailed information presented must be relevant to students' developmental levels. For example, discussions about syphilis, gonorrhea, chlamydia, herpes, and HIV infection would be most appropriate just before young people begin engaging in behaviors that put them at risk for sexually transmitted diseases. Instruction must allow adequate time for full understanding of the health concepts. Students

do not, however, need to know every minute detail about each STD to make an informed decision related to their sexual behavior.

The Office of Disease Prevention and Health Promotion (1991) and the Centers for Disease Control and Prevention (1992) have identified six health priority areas: 1) behaviors that result in unintentional and intentional injuries (e.g., wearing helmets and seatbelts, violence, suicide); 2) use of alcohol and other drugs; 3) tobacco use; 4) sexual behaviors that result in sexually transmitted disease, HIV infection, and unintended pregnancy; 5) imprudent dietary patterns (e.g., crash dieting, binging and purging), and 6) inadequate exercise.

These preventable health-risk behaviors are the leading causes of morbidity, mortality, and disability and should be integrated within all content areas of comprehensive school health education. For example, information about HIV infection, its methods of transmission and prevention would be included in a unit about Diseases and Disorders. However, information about the immune system and how it functions could be integrated in Growth and Development. Discussions of loss and death could be included in Mental and Emotional Health. Activities to build decision-making and communication skills could be integrated in Personal Health. Activities to identify important characteristics of condoms could be included in Consumer Health. Activities to identify community agencies where HIV testing is available could be discussed in Community Health. Remember, as health priority areas change, health education programs should be expanded accordingly.

Recipes: What are the educational and behavioral processes underlying effective health education programs? How should health instruction be delivered so that it will be most effective? The health education curriculum should provide learning experiences to increase students' health-related knowledge, improve their health-related attitudes, and strengthen their personal and social skills. But, how should the key ingredients be mixed together so that the main courses

will be consumed (i.e., which instructional strategies will be more effective in helping young people process information and use skills to make health-promoting decisions)?

To answer these questions, a conceptual framework is critical. When designing instructional programs, health educators can draw from a plethora of theoretical approaches (e.g., social learning theory, social influences theory, social inoculation theory, cognitive-behavioral theory, adoption-diffusion theory, the PRECEDE model, the health-belief model) depending on their program goals and their students' developmental level.

These theoretical approaches offer ways to identify information, attitudes, beliefs, and motivations that affect personal choices as well as appropriate instructional strategies. For example, according to the social inoculation theory, young people can resist social pressures to have sex if they: 1) understand internal and external pressures to have unprotected sex, 2) understand how to resist those pressures, and 3) feel competent in their ability to resist those pressures. Appropriate instructional strategies to help students resist social pressures to have sex should include: 1) brainstorming lists of reasons why young people choose to have or not to have sex; 2) identifying common pressure lines used by their peers; 3) developing and practicing effective strategies and skills to resist pressures to have sex through role plays, case studies, and real-life scenarios.

Main Courses: What are the key elements that should be implemented so that health education programs are more likely effective? Evaluation of programs based on psychosocial theories have identified several key elements necessary for program success (e.g., Bell & Battjes, 1985; Botvin & Wills, 1985; Flay, 1985; Lando, 1985; Schinke, Blythe, & Gilchrist, 1981). Accurate information is essential; however, effective programs should include activities to examine short- and long-term physical, social, emotional, and legal consequences or risks of their health-related decisions. Programs must include activities to help young people identify the internal (e.g.,

wanting to be accepted, wanting to be part of a group, to take a risk, to escape) and external (e.g., peers, parents/caregivers, teachers, media) influences on their personal health practices. Classroom activities also must address misperceptions of normative behavior related to substance use, sexuality, violence, and other health-related behaviors (e.g., everybody's doing it).

Most important, health education programs must offer opportunities for teens to build personal and social skills, an essential part of normal psychosocial development. These skills are critical for dealing with a myriad of situations, problems, and pressures. Most often, teens learn these skills by observing and following adult role models. Inadequate decision-making, communication, goal setting, and stress management skills can affect a young person's ability to have meaningful relationships, make rational decisions, maintain self-control, elicit social support, cope with daily stressors, and achieve future goals.

Seasoning and Spices: What is happening in the school, home, community, and society that could affect processing of health information and using personal and social skills? "The goals of health education emerge from the goals of the society within which it functions" (Nyswander, 1966). Students should be challenged to add to smorgasbord selections by sharing their ideas and examining their personal experiences. No matter how well the curriculum or program is planned, health educators must be ready to adapt it at a moment's notice. Daily interactions with students may create "teachable moments" as unanticipated concerns and issues in school, at home, in the community, and in society as a whole become a priority. For example, classroom activities addressing sexual harassment may be scheduled in three weeks. By keeping with the original schedule, rather than responding to student's questions during the Anita Hill/Clarence Thomas hearings, important opportunities would be missed to make issues relevant and meaningful. Without this flexibility, health education becomes a "static" discipline, unable to meet the needs of

a changing society.

So, the smorgasbord is prepared. The health education menu changes from day to day to reflect the factors described above. The concept sounds simple. But somehow, setting the table is not always enough. Students may approach the table, if they choose, and partake in the selections of their choice. But, will they know which utensils they need?

Critical to the health education feast is a forum that promotes openness and acceptance of individual differences. By making selections more relevant to students, they may become more alluring. Yet, health educators cannot coerce them into tasting the daily selections. "We must keep constantly in mind that the individual's behavior is determined by his motives and his beliefs, regardless of whether the motives and beliefs correspond to our notion of reality or our notion of what is good for him" (Rosenstock, 1960).

Some young people don't believe the information and skills provided on the health education smorgasbord are important or relevant to them. Some don't understand the personal risks of behaviors in which they are engaging. Some aren't willing to experiment with unknown tastes. Some prefer "fast foods" over healthy choices. Some don't feel capable of making choices. And some simply don't care one way or another.

On this health education smorgasbord, emotional health is the principle entree. Not only is it the "main dish," but it gives "freedom of entry" or access to the rest of the selections. I believe that building students' self-esteem, giving them a "sense of pride" will make it easier for them to make choices in the smorgasbord of life.

Clearly, young people with high levels of self-esteem are not only satisfied with themselves but also are able to expand the range of options that are palatable to their taste by trying new things and developing new talents and skills. They are more able to make informed decisions, communicate effectively, manage stressful situations, and ultimately, set and achieve personal goals. In short, they

are more confident as they select and use information and skills provided on each health education smorgasbord.

In conclusion, I believe that each health educator's primary responsibility is to students. We teach children, not health. These young people are growing, developing, and interacting. If we can help them know and understand a little more about themselves and "show them all the beauty they possess inside," then perhaps, they will realize that they do have some control over their future and are capable of making changes, if and when they are ready to change.

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CHAPTER 8

WOULD I DO IT ALL OVER?

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Absolutely! Although I just happened into Health Education before the field even had a name, I would certainly choose it today if I were just starting out. There is a special challenge and satisfaction that comes from involvement in a profession that has such potential for improving the quality of life. The fifty years I've spent in Health Education so far have been stimulating ones I wouldn't have missed. Along the way I've learned a lot.

Eta Sigma Gamma's invitation to contribute to this monograph has given me the chance to expound a few of my beliefs about Health Education. They deal with planning, mentorship, school-community links, professional unity and networks. I present them here in an anecdotal context to suggest how these ideas emerged from my personal experience. Don't look for a chronologically accurate narrative, however; these are selected career highlights to illustrate some pet ideas.

Serendipity and the Limitations of Planning

Like many others, I started out in Physical Education. "A nice college major for a girl", according to my mother, "a vocation, if you need it, and a great avocation after you've met the "right man". My teaching career in Physical Education was very short, not because of the "right man", but because of World War II. This was just the first of many unexpected factors that influenced the direction of my career.

Patriotism impelled me to join the war effort. I became a

USO Director and left my home state of Missouri forever. Starting in Biloxi, Mississippi, then serving at Fort Benning and Camp Gordon in Georgia, I ended up in Washington, DC at the end of the war. I knew then that I wanted a long term professional career but needed further education. New York City beckoned.

There I pursued a Masters degree in Community Recreation and my eyes were opened to mind-body relationships, the concept of total wellness and the influence of culture on health. I discovered anthropology. I knew that I belonged in the health field somewhere.

Serendipity was largely responsible for my getting there. A graduate student I happened to meet at the University invited me to take a one-year position as the director of a Kellogg Foundation Project in School-Community Health in East Texas. It was the most exciting experience of my professional life — one that I would have missed had I stuck to the plan recommended by my faculty advisor.

At the Project's conclusion, I eagerly headed back to New York, this time to study Health Education, with the intent of returning later to Texas. As I finished my doctorate a few years later, "the right man", my beloved Morey, showed up, canceling out my Texas plans in favor of a dual career in the Metropolitan New York City area.

It was still another serendipitous encounter that landed me on the faculty at New York University. This one occurred on a New York City subway and went like this: A professional acquaintance got on my subway car, recognized me and said, "Marian, you have a doctorate, don't you?" "Yes." "We need someone to teach health — I'll telephone you." And he was out the door as the train reached his stop. The career move I made as a result of that unexpected happening resulted in my having the glorious opportunity of establishing and chairing NYU's Health Education Department.

I do believe in planning, but I am convinced you can't plan everything. Unexpected opportunities appear and it is important, I think, to be ready to take advantage of them. Although I have now

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spent many years of my professional life helping students plan their academic programs and their professional careers, I always remind them that changes might be desirable or even necessary. One cannot rigidly follow a plan, no matter how carefully it is researched and developed. And that goes for health education program planning as well. The best planning allows for timely reassessment as a basis for making shifts, and does not rule out the possibility that the whole thing may need to be scrapped.

The Power of Mentorship

I have been blessed with wonderful mentors. The first one from the health field was Professor Arthur Steinhaus of George Williams College in Chicago. I came to know him through his service on an Advisory Committee to the YWCA Health Education department which I headed for a few years. He also sent his students to our agency for field experiences with the Central American immigrants who were flooding the city then. He provided his students and me with a philosophical understanding of the human need to be accepted, understood and appreciated. With his tutelage I also came to understand the importance of volunteerism, both to providers and consumers. I felt honored beyond belief when he gave me the opportunity to attend his workshop on Health Education, possibly the first in the country. His encouragement was largely responsible for my continuation in voluntary health agency work for eighteen years and for my lifelong commitment to service as a volunteer in some capacity.

A later mentor was Dr. John Ferree, Medical Director of the National Office of the American Heart Association, where I served as School Health Consultant. By this time I had had plenty of experience working with medical doctors; none had offered the kind of education and support I got from him. He took time to know me as a person; he taught me about public health; and together we strengthened the relationships between the medical and education staffs. He inspired creativity and could always be counted on for support.

I can't think of a more powerful force for good than know-

ing that someone who is highly esteemed by professional peers believes in you. The inspiration that derives from such knowledge can boost a person's achievements way beyond perceived capability. Nor can I think of anything more satisfying than being a mentor, feeling that your guidance and encouragement is making a difference in someone else's life.

I believe in mentorship. Its power incorporated into health education programming has enormous strength for influencing positive health behaviors. It is one of our basic professional tools, not used often enough.

The School-Community Link

I was lucky early in my health education career to direct a Kellogg Foundation project entitled School-Community Health. It was my job to organize and work with health councils that had representation from the whole community, including schools. We worked together on such projects as community sanitation, drug education and school lunches. There was never any separation between school and community.

In subsequent positions at the state and national levels, I found a totally different situation. The school-community linkages that were so natural in those small Texas cities were practically non-existent in state governments. As I helped states organize for the polio vaccine field trials during my tenure at the National March of Dimes, I found little communication between health educators in state education departments and those in state health departments. In some cases, I brought the two of them together for the first time.

I have seen the same thing recently in my consultant work in the Eastern Carribbean. In several countries family life education programs are seriously hampered by the lack of cooperation between health and education department personnel.

Of course, some health education work is focused more on schools and some on other parts of the community, but it is an unnatural and non-productive separation. Almost any school health

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program needs community involvement, and community, by its very definition, includes schools.

I believe that effective health education programming requires appropriate inter-sectoral cooperation, and that health educators, regardless of the source and emphasis of their professional preparation, must be its facilitators. School-community can be one world.

Professional Unity

I joined the American Association for Health, Physical Education and Recreation as an undergraduate student. It was my first professional association membership and continues today in the subsequently established Association for the Advancement of Health Education (AAHE). In the mid-forties when I became the director of a school-community project, I joined the American Public Health Association (APHA) and immediately became aware of the separateness of school health education and community health education because I had to choose a section with which to affiliate, and there was one for each. I opted for school health education. Not long afterward, I also became a member of the American School Health Association (ASHA) because of its excellent journal.

The perspectives of these three national associations (AAHE, APHA, ASHA) vary in ways that reflect their origins; each has a slightly different mix of members, but their missions are similar. There are health educators in each of them, some, like myself, are in all three.

The split between school and community health educators became even more apparent to me with the establishment in 1950 of the Society of Public Health Educators which limited its membership to public health educators. This caused much resentment among school and other types of health educators who were not eligible. It was fortunate, I think, that the organization did not continue with its original membership restrictions and that subsequent leadership saw fit to change the organizations name to the Society for Public Health Education and to open its membership to health educators, regard-

less of work setting.

In the sixties and seventies we wasted too much time and energy on internal struggles, greatly delaying progress toward becoming an established profession. In 1978 some of our enlightened leaders had garnered resources to hold a national workshop on commonalities and differences in the preparation and practice of community, patient and school health educators. I will never forget the violent arguments and the high noise level of those group discussions as the community, patient and school health educators were fiercely protecting their pieces of the Health Education turf. Although I was categorized in this workshop as a school health educator, I never felt this was an accurate designation for me. By this time I had been employed as a health educator for thirty years: twenty of them in health agencies and ten in a university — not one in a K-12 school setting. I had little patience for the intra-professional squabbling, although it was clearly important to debate the issues openly.

We are making tremendous accomplishments toward strengthening our professional unity. The Coalition of National Health Education Organizations (CNHEO) provides us with a single voice when needed. The establishment of national voluntary health education certification through the National Commission for Health Education Credentialing (NCHEC) is evidence of our basic commonality.

I believe that health education is a single profession and that all health educators need to emphasize the profession's unity. An important part of this is membership and active participation in the organizations that represent them. I believe in the value of professional organizations, but suspect that the profession might be better served by fewer rather than more. Still, it is apparent to me that existing organizations will thrive and new groups will come into being as long as they are meeting the special interests of our diverse professional population.

I believe that we need to put more of our resources into joint efforts and coalition building. I believe that much of Health

Education's future as a profession depends upon the support that health educators, regardless of their specialized training, provide for the maintenance and expansion of certification through the National Commission for Health Education Credentialing.

The Strength of Networks

The first time I ever thought about the strong bond that exists between people engaged in the same occupation was when reading one of Thomas Wolfe's novels. He described the natural affinity of people who work in the same field. An invisible chord that attracts them to each other can be stronger than that between family members, he said. Writers relate to writers. Engineers to engineers. Physicians to physicians.

It made me realize very early in my career that some of the people to whom I felt closest were those in the health education field. It didn't seem to matter that I knew some only through their writings and their speeches; some, through infrequent encounters at professional meetings; and others, through regular association in mutual endeavors. Networks had not yet become a buzzword in the profession, but I had a network of professionals all over the country that I knew I could count on for support because of our common basis of understanding. Through the years my network has grown in size and strength and has brought me — and allowed me to give to others — all kinds of important help. Letters of support for grant proposals, responses to critics of sex education, guest lecturers for classes, opportunities to work on special projects, reports and other materials to which I might not have had access, job announcements, expressions of support and hundreds of helpful discussions about all sorts of professional concerns.

It is not at all surprising to me that the concept of networking has become an important basis for health education practice. We bring together people with common problems to seek solutions through the sharing of feelings and information. We have seen that these support groups can work in astounding ways to help people

lose weight, give up smoking, gambling, drinking or a host of other things. I believe we are only beginning to realize and appreciate that our health education connections have the same potential. Although a collegial network develops naturally, I believe that a conscious effort to nurture and intensify relationships can increase professional capabilities and satisfaction in surprising ways. I have seen it happen.

A career in Health Education? Yes, I would do it all over again, and I wouldn't do anything differently.

CHAPTER 9

CHANGING EXPECTATIONS OF HEALTH EDUCATION

Joyce W. Hopp, Ph.D., MPH, CHES

Expectations of what health education can do have always been high. At least, that has been so since the words "health education" entered the lexicon of public health. The history of health education is replete with examples of high expectations. If we just teach people how to improve their lives through better health habits, just think what we might accomplish! A disease-free nation, a disease-free world.

In the 1920's, elementary educators indoctrinated school children with health information, often cleverly disguised in jingles, stories and gold star charts, expecting to produce a generation of healthier children than those who had failed the draft in 1917. The results of the 1942 draft revealed their failed expectations.

In the 1940's, newly minted public health educators educated parents to immunize their children to prevent the spread of communicable diseases. Their success rate lasted nearly an entire generation--until the low level of the diseases made it appear that such diseases were history. Then parents who could not remember the diphtheria or whooping cough epidemics of an earlier generation no longer saw the importance of immunications for their children.

In the 1950's, we tried to educate dental decay out of existence, through fluoridation of community water supplies and toothpaste, and a campaign against sugar snacks and drinks. I say "we" because I entered the field of health education in 1951. I entered with the enthusiasm of youth, who think they can change the world.

I had high expectations of what health education could do. I joined the cadre of health educators who thought if people just knew what to do, they would do it. Give'em facts!

Theory Intrudes

A year later an MPH program at Harvard School of Public Health shook my confidence. Beryl Roberts was doing her best to introduce behavioral science theories into health education; I was one of her unwilling students. I really didn't want to think about all the factors which influenced the behaviors of people; the behavioral sciences raised too many questions. Gerald Caplan, a psychiatrist then occupied in collecting a series of case studies from many countries, led us in analyzing the potential reasons for failure of health education in cross-cultural settings. It was difficult for us to accept that the women of Peru wouldn't lower incidence of water-borne diseases in their children because they refused to boil their drinking water. Reliance on knowledge as the primary means of changing health behaviors died hard among us!

We had not learned the lesson by the 1960's when drug abuse began to spread through the schools, cities and suburbs of the nation. Educators persuaded the government to pour large sums of money into drug education; they were confident in their expectations that health education would solve the problem. Those of you who recall the 60s remember the glamorous job we did of drug education. In fact, we frequently made drugs so enticing that the rate of abuse climbed in the schools!

By 1970, I was searching for answers to questions which my experience in health education had raised. Somehow, I felt it must lie in motivation. Others had often asked me, as a health educator, to teach them how to motivate people. Physicians would ask it for their patients; teachers would ask it for their students. I would always glibly reply, "Motivation comes from within; it isn't something you do from the outside...the best you can do is to create an environment in which motivation may occur." But my attempts to describe

that environment often left me and my interlocutors confused.

Enter Values Clarification

My search led me into doctoral study in health education. One of my first assignments was to review every doctoral dissertation done in health education in U.S. universities in the previous decade. I thought my professor was overdoing it, definitely looking for a likely victim to provide a fresh perspective for her teaching! But the search proved fruitful when I discovered Jack Osman's dissertation, completed the previous year at Ohio State University. Jack had a penchant for clever phrases, and when he pointed out that "values clarification narrowed the gap between creed and deed," I felt I had found the missing link in my health education. I built my doctoral research on the leads he provided—and it profoundly influenced my teaching in the professional preparation of health educators.

Choosing, prizing and acting—these were the major processes proposed by Louis Raths whose research had inspired Jack Osman to apply values clarification to health education. Facts had a place, they formed the basis for personal choice, but until one took health education to the value level, little of lasting import occurred according to Raths. The value-clarifying process, I discovered, could be applied with equal facility to patient education, school health education, community health education, and the education of health professionals.

I watched with dismay, however, as values clarification became suspect in many school districts. Parents wanted to know whose values were being taught, and questioned the use of certain value clarifying strategies. Many of the parents who raised these questions were fundamentalist Christians. Since I considered myself a Bible-believing Christian, their criticism drove me to examine my own use of the approach in health education. My analysis: values clarification is a sound approach, in which Christians can participate so long as they make one initial choice. That choice is to accept an outside authority (for a Christian, it would be God) who ultimately

provides guidance in all other choices. That choice in itself is a value to a Christian. I realized, however, that was a difficult, if not impossible, concept to implement in public schools. That is the bind fundamentalist Christians get themselves into when they try to tell public schools what values they must teach, and how they must teach them.

One Theory Does All

Health educators, in their attempts to become "theory-based," often grasped one or two psychological theories and sought to explain all health behavior by them. Witness the application of the Health Belief Model or locus of control to as wide range of health problems. You could almost close your eyes and predict what theories you would find in the health education journals of each decade. Fortunately, health education appears to have outgrown that tendency by the 90s.

Cost Effectiveness

The 1980s also brought the challenge of demonstrating cost benefit from health education activities. The difficulty was that other health professionals were wanting health educators to pull their chestnuts out of the fire, i.e. health education was to control costs of health care. Again, we faced unrealistic expectations of what health education could accomplish. Oh, we tried, as health education literature of the 80s demonstrates. Somehow, as a health educator, I object to being asked to control costs that other forces-and professions--are creating. It is ironic in light of these expectations, that when cost-cutting in agencies or institutions must be done, health educators are frequently the first to be cut. They are considered "luxury services."

AIDS Epidemic Challenges

With the advent of the AIDS epidemic in the 1980s, we realized that public health did not have all the communicable diseases licked. Should we revert to the approach of the 1920s and throw more facts at people? No, because we have learned a lot in the last 50 years. We turned, instead, to the behavioral models supported by

the studies in social psychology, and to epidemiological studies which revealed modes of transmission and high risk behaviors. For health education is built on these two fields; health education is only as strong as the evidence provided by them.

The only weapon with which we can fight the AIDS epidemic is education. True, research in the development of drugs for treatment and vaccines for prevention will add other weapons--when, and if, they are successful. But education stands alone just now. And the expectations are very high. Can we change people's behavior enough to slow the spread of this disease?

One of the primary ways in which the HIV is spread is through sexual activity. Health educators are emphasizing abstinence, wait until marriage for sexual intercourse, then remain faithful to one partner. This recalls to mind, however, a comment in an editorial in the American Journal of Public Health. An army medical officer in World War II is quoted as saying, "It is difficult to make the sex act unpopular." Apparently, the same could be said of drug abuse. Health educators are up against massive societal behaviors, which will call for all their skills and the application of all their theories of behavior change.

Health Policy, Too

Currently, health educators are exhorted to be proactive in affecting health policy. Speak up! Speak out! Form coalitions. Lobby the legislators. Be at the table where the decision-makers gather. If we don't get in on the action, we will be left out.

Actually, health educators have always had to be political; they cut their eye teeth on achieving consensus among groups with disparate goals. The skills of community organization were part of their armamentarium long before the activist days of the 60s. They were providing their clients with self-help skills long before the buzzword "empowerment" came along.

Are the expectations too high? My personal odyssey in health

education tells me that this is so. But we will continue to be super-achievers. It is our mission to continue to seek better ways, and more answers.

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CHAPTER 10

ONE PERSON'S PHILOSOPHY OF HEALTH EDUCATION: 1993

Susan Cross Lipnickey, Ph.D., J.D.

Introduction

A philosophy of health education is influenced by a variety of factors which are continuously evolving. Those influences include, but are not limited to, the writing and teachings of educators in general and health educators more specifically; professional, as well as, personal experiences; major and minor life events and world events. This philosophy of health education is premised on each of those and all of those; it is, then, a philosophy of health education for one person in the year 1993. It is not the philosophy that would have existed for that person in 1983; nor is it the philosophy that might exist in the year 2003. In turn, one's philosophy is determinative of who and what the health educator is.

Health education exists in different and varied forms, yet, it is appropriate and warranted for all people; that is, for people of both genders, all ages, all nationalities, all races and all religions, regardless of their state of wellness. What is both the challenge of health education and significant is that the when's, the where's, the why's and what's of health education differ according to the population for whom and with whom it is designed. While it is often assumed that health education must occur in certain places and at certain times, and even according to prescribed or predetermined guidelines, that is neither realistic nor effective;what is realistic is that health education may occur in the home, on the playground, on the street, in the school, in the factory, or in the boardroom. What tends to discrimin-

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ate health education from the mere dissemination of health information is the who...

The Who

Quality health education is provided by qualified individuals who have participated in professional preparation programs; individuals who can provide for their clients, be they students, patients, white collar workers, factory workers, or members of a retirement community, learning opportunities and situations which will enhance the health and ultimately, the quality of life, of those clients. In some cases those opportunities may involve merely the dissemination of current health information; that is, a presentation of selected facts and figures that will provide the clientele with a working knowledge of a specific domain of health permitting those individuals to make informed decisions. In other cases, those opportunities may include the teaching of specific skills that enable individuals to successfully adopt and maintain those behaviors that enhance one's health status and quality of life. And, in even other cases, those opportunities may include the exploration of values, attitudes and beliefs that both influence one's behaviors and are influenced by one's behaviors. It takes a unique individual to be able to create and provide those opportunities; the individual must, of course, have a sound knowledge base from which to work, including a commitment to remain current with that ever-changing health information base; interact readily and easily with a variety of people; be tolerant of persons as individuals and their differences and appreciate their viewpoints; effectively communicate with others; understand the hows and whys of health behavior and be able to take that understanding one step further to assist individuals in changing or maintaining appropriate, health-enhancing behaviors; possess positive approach tendencies; be strong; be non-judgmental of others; and possess a strong moral and ethical base which serves as the foundation for all aspects of health education.

The Why

Why do we even have health education? The ultimate goal of health education is that of enhancing the quality of life of individuals who are participants in the health education program; it is, after all, the quality of life which ultimately matters and it is one's health, that combination of the physical, emotional, spiritual, intellectual and social dimensions, which determines the extent to which one can "live" and participate in a high quality of life. The means of enhancing the quality of life and improving one's health status is via health education as prevention. While prevention occurs at three levels: as with other aspects of prevention, certainly the greatest impact potential of health education is at the primary level where it is utilized to assist people in adopting those behaviors, with the requisite knowledge and appropriate changes in attitudes and beliefs, which are healthy or not adopting "unhealthy" behaviors prior to the time when there have been adverse consequences from the presence or absence of those behaviors. Health education also can impact at the secondary level of prevention as it goes hand-in-hand with screening and early detection; of what benefit is a cholesterol or blood pressure screening without the education to go along with it to assist an individual in obtaining a desirable level? Tertiary prevention, that which is part and parcel of rehabilitation and "fixing that which is already broken" is probably the most ineffective use of health education; however, health education is appropriate and can be effective here as well as it serves to "retrain" or assist people in dealing with existing health problems and maintaining the status quo. Research supports the notion that health education is not only effective in enhancing the quality of life, but in all of the areas of prevention, as well.

The What

What health education should include is a question not easily answered for the "what" of health education should be determined by the needs and interests of the clientele, by the professional health

educator in conjunction with his/her clientele. Too often, we in health education, tend to think that we know what is best for the population we have been hired to educate. The what of health education, then, should not be determined by the health educator in isolation, but as a joint venture between the health educator and the future participants; it is a joint effort and one which should be undertaken as such. That what, then will not only vary across populations, but within populations over time. It is the expertise of the health educator which can assist in first determining the needs and interests of the clientele and then utilize the results of such a determination to develop a sound, relevant and comprehensive health education program for the population being served, which program recognizes and addresses those factors which influence the health and well-being of the clientele.

The what, regardless of the specific needs and interests, must also address the five dimensions of health (emotional, intellectual, spiritual, physical and social); recognize that health does not occur in a vacuum; convey the concept that while health is a combination of knowledge, attitudes, beliefs, values and behaviors, it is ultimately the behaviors adoped which will impact most significantly on one's health; and determine the individual, hereditary and outside influences which may effect one's health.

The How

Regardless of the setting and regardless of the population, health education must actively involve the learner; utilize a variety of teaching and learning strategies which are appropriate for that particular situation; take advantage of the technology and media available; and create an environment which is safe, positive and which fosters learning and growing. Health education does not and cannot just happen; rather, it requires systematic planning, implementation and evaluation, grounded in educational theory and practice, which will enhance the opportunities for success.

Conclusion

Health education is, as is health, dynamic; it must remain

current and continuously meet the needs of today's population. It does not exist within the bounds of the needs of society. It will. given the changing demographics of the population, the ever-increasing concern to provide quality health care for all with a simultaneous recognition that the key to quality health care is prevention housed within effective health education, continue to evolve. The appreciation and support for and the recognition of, health education will only increase as we move to the year 2000 and move into the 21st century; health education is one whose time has come.

CHAPTER 11

REFLECTIONS OF A SCHOOL HEALTH EDUCATOR/ADMINISTRATOR

David K. Lohrmann, Ph.D., CHES

"If I were to read, much less answer all the attacks made on me, this shop might as well be closed for any other business. I do the very best I know how, the very best I can, and I mean to keep doing so until the end. If the end brings me out all right, what is said against me won't amount to anything. If the end brings me out wrong, then angels swearing I was right would make no difference."

Abraham Lincoln

I am presently an administrator with responsibility for all curriculum development and implementation in a local school district. Until two years ago, my "only" responsibility was the school health promotion program. While I have been a high school health teacher and university professor, my present point of reference is that of an administrator who has worked internally for the past seven years to develop and implement a comprehensive school health promotion program. During that time, changes have been made in all eight components of school health promotion. These include total revision of the K-12 health education curriculum, development of a 6-12 student assistance program, initiation of an employee wellness program, and implementation of a community-wide coalition to pre-

vent substance abuse. Not surprisingly, the most contentious and controversial issues have been sexuality education and AIDS education.

I came upon the Lincoln quote above when the issue of whether to teach about condoms in the curriculum was debated for at least the third time. This quote had a lot of meaning for me at the time because I was exasperated and I felt like I was under siege. So, I copied it and hung it on my office wall. Since then I have come to appreciate two lessons contained in it. The first is self-evident, "Always do your best and the ending will work itself out." The second is a conclusion based on what I know of Lincoln's life, "It's important to keep things in perspective. Our battles seem important at the time, but others have endured much worse."

I have been fortunate in my career to have received some excellent guidance from professors, principals and supervisors. I consistently learned from these mentors that the first and foremost guiding principle is to always do what is in the best interest of children and youth. This may not always be the safest or easiest thing to do and you might not always win your case (at least in the short term), but a health educator can never go wrong by following this principle. If nothing else, you will gain the respect of supporters and detractors alike if this is clearly perceived as your primary motivation.

Another principle that has served me well is to keep extremely well informed. Do your homework! This principle has three aspects. The first is to keep extremely well informed about current research and trends in health education and related fields. The second is to keep extremely well informed about developments around you (who is doing what; who is concerned about what; who is criticizing what). The third is to use local data whenever possible, for local data has more meaning in a community than state or national data. In many respects, health education embodies marketing and persuasive communication. If you are well informed and well net-

worked, you will be in an excellent position to advocate for and/or defend what you are doing or intend to do.

An extension of this principle is to use your knowledge to keep superiors and decision makers well informed. They will feel more secure if they have a good command of the issues. Eventually, they will come to view you as a credible and invaluable information source. Remember, you may never be able to convince opponents of your position and you do not have to convince supporters. You need to convince those listening in from the sidelines who may originally be disinterested or who have not made up their minds. This is usually the largest group and often includes decision makers. If you convince them, you will prevail.

The principle of being well informed really boils down to gaining authority. Authority can be formal or informal, official or unofficial. Since health educators seldom have formal or official authority in school systems, they must rely on their perceived level of competence and expertise to establish authority. Informal or unofficial authority based on competence and expertise is the strongest form of authority.

The final principle I have come to rely on is to be as "public" as possible. Health policy and curriculum decisions need to be considered and made in full view of the community. Nothing does more to dispel rumors and build trust than a willingness to hear all sides and consider all points of view. Opponents may not appreciate it if they do not prevail; however, they do appreciate the opportunity to be heard. Once trust is established through openness, it is possible to build strong bridges with the most crucial group within the school community—parents.

My career in health education began as a high school teacher. My first position was created in response to the alcohol, tobacco and other drug (ATOM) abuse problem in the early 1970s. The prevailing wisdom of the time was that this was a youth problem. Therefore, schools should handle it and prevent it from happening. A col-

league and I developed a comprehensive health course in 1972 with a strong mental health component, a solid knowledge foundation, and built-in alternatives to ATOM use. We were strongly influenced by the affective education movement and were advocates for teaching decision making skills. Based on what we knew then, we were doing all the things that would solve this and other problems.

Years later I read an article by Kolbe, Iverson, Kreuter, Hochbaum and Christensen (1981) that brought clarity to the following questions which had always troubled me. How could I be held responsible for the health behavior of my students once they were outside of my classroom? Why didn't health education seem to work in influencing major adolescent health problems? Why were schools being criticized for not solving problems they did not cause?

Kolbe et al introduced me to several key concepts which I have incorporated in my professional practice ever since. The first was that health educators are responsible for teaching students the knowledge and skills needed to make decisions about health and, then, the competencies and skills to sustain healthy decisions in their lives. What a relief! I could be responsible for that! It seemed much more reasonable than the burden of having to be responsible for my students' eating, exercise, drug use, sexual behavior, etc. which seemed to be the expectation of society.

Kolbe et al also stated that "we do not expect that health education alone is sufficient to bring about behavioral adaptations. That, we propose, is the broader function of health promotion." (25) This also made much sense to me. In order to sustain positive health behavior in teens or to change behavior, the behaviors taught in school health had to be supported by family, community and society norms, both stated and modeled. It dawned on me that the reason I didn't seem to be making much headway in ATOM abuse prevention was that society, including many parents and public policy makers, was supporting ATOM use. The models youth saw, especially in movies, often depicted and glorified ATOM use. Commercials promoted over-

the-counter drug and alcohol use. Affluent professionals snorted "non-addictive" cocaine. The government seemed helpless to prevent illicit drug trafficking and was virtually silent about tobacco and alcohol.

When I combined this information with the newly-reported findings on adolescent ATOM abuse risk-factors (Jessor, 1982), it became clear to me why health education seemed to be ineffective. Many of the ATOM risk factors had little or nothing to do with schools or, for that matter, health education in isolation. New research seemed to be indication that other institutions such as the family had much more influence over this problem than schools.

The final important aspect of the Kolbe et al article was that it introduced me to the PRECEDE Health Education Planning Model.

In 1984, the Rand Corporation published a review of ATOM prevention (Polich, Reuter and Kahan) which said that neither law enforcement, treatment nor school-based education worked, but that school-based ATOM education was the best bet for solving the adolescent ATOM abuse problem. I couldn't believe what I was reading and angrily wrote an article with a colleague (Lohrmann and Fors, 1985) which argued that (1) this expectation of schools was unfair and (2) that it should only be accepted by schools if consistent resources were allocated over time, if targeted programs were provided for high risk youth such as children of alcoholics, and if other social institutions accepted their fair share of responsibility for the problem and the solution. We "loaded" the adolescent ATOM risk factors in the PRECEDE Model to illustrate our point.

Since 1987, I have been fortunate enough to be in the position to test our contentions, as expressed in this article, in the field. With the assistance of numerous others, I am attempting to demonstrate that the adolescent ATOM abuse problem can only be effectively addressed through a combined school, family and community prevention effort which changes community norms to non-acceptance of ATOM abuse among all ages and all groups.

Through this work, which in many ways was triggered by reading an article in 1981, I have come to conclude that school health education cannot be practiced in isolation from community and public health. The Eight Components of School Health Promotion Model identifies integrated school and community health promotion efforts as one component. All eight components are important, but I believe this one holds the key to truly influencing the health behaviors of children and youth. As evidenced by the trends in declining cigarette smoking and illicit drug use, when the community reinforces and promotes health behaviors, school health education efforts meet with greater success.

School health educators need to build strong alliances with community and public health promotion leaders. And, community and public health professionals need to wake up to the need to include school health promotion and school health educators in their health promotion plans. School health can no longer be viewed by either party as separate or apart from events and efforts taking place in students' greater environment outside of school in the community.

Despite the recent attacks on school health education by the radical right, signs are appearing which show that the efforts of school health advocates over the past 10-15 years have been successful. In the past, educators often begrudgingly accepted health education in the curriculum. Frequently, the inclusion of health education or health-related topics in the curriculum was disparaged for taking time away from "real education". That perception has changed. Several recent reports including Turning Points Preparing American Youth for the 21st Century (Carnegie Council on Adolescent Development, 1989) devote extensive attention to child and adolescent health issues and strongly advocate for school health promotion. More importantly, a broad national base of educational administrators has come to recognize the importance of health education in the curriculum (Abbott et al, 1991).

Health educators need to carefully track current developments

in education including cooperative learning, curriculum integration, outcomes-based education and the use of technology. Then, they need to exploit these developments as opportunities to demonstrate that school health promotion should be in the forefront of the school agenda. If school health educators keep well informed, if they carefully coordinate with community and public health promotion efforts, school health will attain a prominence and success as never before by the turn of the century and beyond.

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CHAPTER 12

Three Essential Questions in Defining a Personal Philosophy

R. Morgan Pigg, Jr., H.S.D., M.P.H.

Early on Christmas morning, 1959, my dad and I got into the car and began an important journey in my understanding of life. Heavy snow had fallen on Christmas Eve. Dad drove slowly for hours through the Tennessee hills until we stopped outside a sharecropper's shack near the Alabama state line. A large man emerged from the shack and labored through the fresh snow toward our car. A little boy not more than four followed several feet behind in his footsteps.

Dad opened the trunk, took out a new tricycle, and gave it to the man. The little boy watched from a distance. The men shook hands. Neither said much. As we drove away I watched out the back window as the little boy plowed through the snow on his new tricycle. Even at age 12, I knew something special had happened. That Christmas morning remains a defining moment in my life.

Philosophy Defined

Philosophy involves the intellectual pursuit of wisdom and knowledge. It represents one of four terms related to defining human behavior. "Philosophy" involves a process to identify, classify, and explain knowledge. "Ethics" defines acceptable and unacceptable behavior within the norms of a particular group. "Morality" sets standards for right and wrong in human behavior. "Religion," or spiritualism, addresses good and evil behavior, often in terms of eter-

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nal consequences.

Thus, philosophy describes human existence without necessarily judging it. Judgment comes in the form of ethics (acceptable/unacceptable), morality (right/wrong), or religion (good/evil). The four terms should not be confused since they represent related but distinct concepts. Therefore, avoid considering the concepts collectively as in "philosophy and ethics."

Ancient philosophers loved knowledge and devoted their lives to the search for meaning in human existence. Defining three central components — reality, truth, and value — formed the basis for that search. Over time three traditional schools of philosophical thought emerged: idealism, realism, and pragmatism. Contemporary schools of thought include existentialism, naturalism, humanism, theism, and eclecticism. While the schools differ in detail, all approach reality, truth, and value by addressing considerations such as the relationship of human beings to nature, the relationship between individuals and society, the relationship between mind and body, sources and consequences of human behavior, the absolute or relative nature of values, the meaning of the physical world, the role of science in defining human existence, and the nature and involvement of God in human existence.

Three Essential Questions

While studying philosophy as an academic subject can prove interesting, the process may provide students with limited help in forming a personal philosophy. Formal courses often focus on the history of philosophy, rather than developing methods of philosophical thought among the students. They study the writings of past philosophers, or what others have written about those philosophers. They spend time talking about philosophy, rather than developing their own abilities as philosophical thinkers. Consequently, they gain knowledge but fundamental questions go unanswered. They leave the course better appreciating Plato or Idealism, but lacking confidence in their own explanation of human existence. Unfortunately,

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the abstract nature of the experience can discourage students from further contemplation.

Philosophy need not be an abstract process. You and I still face the same fundamental question as did Plato or other great philosophers: "What is the origin, nature, and purpose of human existence?" Or, treating the matter as three essential questions, Where did I come from?, Why am I here?, and What happens to me after I die? To be viable, any philosophy must provide satisfactory answers to these questions.

Given the knowledge available today, we have at least as good a chance, or perhaps a better chance, to successfully answer the questions as did the ancient philosophers. Answers to question one (Where did I come from?) fall into three categories: creation, evolution, and fate. Options one and two both require faith since neither can be proven with complete satisfaction, especially to an unreceptive listener. If creation, then by whom? If evolution, then from what and to what? Fate merely accepts, without explanation. Answers to questions two and three (Why am I here? Where am I going?) derive from the answer to question one since, logically, the explanation of origin will influence one's views of current and future events.

Implications for Health Education

What role does philosophy play in Health Education? Think of philosophy as the solid foundation upon which we build the house of professional practice. We need both to be successful.

Professional preparation programs in Health Education have improved dramatically the past several years, particularly in developing student knowledge and skills. Our major students display impressive ability in areas such as conceptualizing the discipline, planning and evaluating interventions to document effectiveness, applying computer technology to instruction, and acknowledging the importance of cultural diversity.

Yet, much of the improvement centers on the "how" rather than the "why" of Health Education. We provide a strong defense

for the process of Health Education, but prove less effective in presenting a fundamental rationale for its existence. For example, we can confirm the effectiveness of smoking cessation strategies, but we falter in providing a convincing rationale for assisting the individual smoker. Beyond offering general comments about reducing medical care costs, or contributing to self-actualization, we often fail to show why that one smoker is worth the effort. Discussions of health as a right, for example, are premature without first confirming the inherent worth of the person for whom we advocate that right.

Accepting individuals as unique and valuable, regardless of their circumstances, provides a foundation for dealing positively and professionally with our students, patients, and clients. The concepts of anonymity, confidentiality, informed consent, and voluntary participation in research are particularly important in this regard. Likewise, personal philosophy allows us to confidently address important topics more specific to the field such as defining the concept of optimal health, examining the relationship between free will and determinism, or explaining why one smoker is important. Philosophy won't always give specific answers, but it provides a context for answering questions and making decisions.

Professors frequently ask students to speak or write about their professional philosophy of Health Education, often with no link to personal philosophy. Consequently, these experiences sometime remind us of efforts to define patriotism or family. As a young professional, I found the dichotomy disconcerting since in my own thinking the two philosophies invariably merged. Today, students still struggle to reconcile that dichotomy. Once we understand that personal philosophy begats professional philosophy, then we understand the application of philosophy to professional practice.

Using the three essential questions posed previously as a guide, students can develop a foundation upon which to derive a personal philosophy. For example, let me share with you briefly the essence of the personal philosophy that gives direction to my profes-

sional practice. I believe Creation provides the most reasonable explanation for human existence (Where did I come from?). Deity endows each human being with a life force, or soul, making every human being inherently unique and valuable. Human beings exist to serve Deity, and we render that service in part by helping other human beings in our common journey toward an eternal existence (Why am I here?). Through successful service, we serve Deity for eternity in the afterlife (Where am I going?). I also believe in ultimate justice where good eventually triumphs.

A clear philosophy of the purpose for human existence can significantly influence our approach to personal and professional relationships. For example, a professor labors against an impossible deadline to complete a critical project when a student knocks, sticks her head in the door, and asks, "Do you have a minute?" In this situation, you know two things. First, you don't have a minute, and second, even if you do, the matter will take more than a minute. What do you do? Time management tells us to lock the door, pull the shade, and turn off the light, but a philosophy that views the individual with respect and value says to help now, or at least make certain the need isn't urgent or life-threatening.

Some would question the preceding example, suggesting we should take time for ourselves. While we all need time for ourselves, Americans have elevated self-care to an art form. Since helping others usually requires sacrifice, a clear philosophy confirms the purpose and importance of serving. While anyone can render acts of service, those who work from a sense of right and duty (or love) often serve with contentment and conviction for a lifetime. In this sense, service represents as much an attitude as an act. Even on "bad days," a philosophy grounded in service sustains us in helping our students, patients, and clients — especially when they don't deserve it or appreciate it. Conversely, service without substance eventually fades, leaving the individual frustrated and disillusioned.

Conclusion

I'm reminded again of that time with my dad on a snowy Christmas Day in 1959. Dad was not a politician or social activist. He just believed in people. He respected them, accepted them, and related to them as individuals regardless of their circumstances. He particularly loved children. That year, dad worked at a furniture store. The sharecropper had bought the tricycle as a Christmas present for his son, but he had no car and the snowstorm prevented his picking it up on Christmas Eve. Dad knew that without the tricycle, the little boy would have no Christmas. He saw a need, and he met it. That act was especially significant in 1959. The little boy was Black.

Dad died on October 6, 1992, at age 80 following a 10-year struggle with countless health problems. The experience jaded my view of modern medicine, but Dad didn't complain. Rather, he accepted the situation and endeared himself to the countless medical workers who filled his life. His passing left a small hole in the universe, not so much for his worldly accomplishments, but for the quality of his character. He successfully answered life's three essential questions. I often pose this question to my students: "If we could master all the knowledge of a great university, yet not provide a reasonable explanation for the reality of human existence, what have we learned?"

What kind of hole will you and I leave in the universe? If we can face that proposition with confidence, then we understand life, and we are ready to apply our philosophy to the professional practice of Health Education in any setting under any circumstances.

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CHAPTER 13

ANDY'S QUESTION

Candace O. Purdy, M.S.

I had just finished giving my very organized lecture on the structure and function of the digestive system. Most students were dutifully taking notes except for Andy. He just crossed his arms and stared at me. Finally, he raised his hand and asked, "What good does it do us to know about all these organs? Will it help us avoid cancer or ulcers if we know the digestive enzymes made by the pancreas?"

I had no answer because Andy had discovered that parts of our health curriculum did not address his needs or the needs of his classmates who were increasingly exhibiting health problems like anorexia, suicidal tendencies, depression and drug abuse. His message was clear and I was grateful to hear the bell that signaled the end of the class period. Andy was a turning point in my career many years ago, and in my philosophy of health education, because he asked about accountability; there was none for many of the topics in the "old style" health curriculum. Pumping students full of facts about anatomy, physiology and the classes of drugs did not alter the behaviors that were threatening their lives and their happiness.

A Philosophy of Health Education

The philosophy I follow today can be simply stated by saying that health education should teach students what they need to know in order to live healthy lives and give them a chance to practice making healthy choices. This philosophy does not eliminate the need

for knowledge by any means, but it does give direction in selecting the knowledge to be presented and the methods we use in the classroom. Because our present day health curriculum contains such a large volume of topics to be presented in so little time, it is critical that what we present be relevant to students' lives and needs.

We came to this point in health education the hard way, as we doggedly continued to teach anatomy and physiology while health problems surfaced in youth and then we tried to find a bandaid for these problems. Administrators called it being reactive instead of proactive. Teen suicide, anorexia/bulemia, steroids, cocaine, alcohol and child abuse crept into students lives as we sought ways to insulate students against these critical health problems. We began to see that choices and decision-making, refusal skills and coping mechanisms were the artillery against peer pressure. Suddenly teachers' backgrounds in "physical education and a couple of health courses" seemed woefully inadequate for teaching "today's" health education classes. Progressive school systems recognized that physical educators were not equipped to teach the new health education and began to hire health educators to present comprehensive health curricula. Schools began to address the needs of today's youth instead of the needs of the teachers who felt prepared to present only a limited amount of today's health curriculum.

The Role of the Health Educator

Today, the role of the health educator is twofold. First, we still need to present information upon which students can base decisions. I recently attended a meeting of some of the top health educators in the country and I was dismayed to hear one individual say that after all, cognitive information is not important in health education. He was referring to the affective domain; but to assume that students have all the knowledge they need in order to make healthy decisions is an overestimation of their backgrounds and ability to glean from the media all they need to know. My recent experience with student

teachers in health education has suggested to me that some college preparation programs are lax in providing factual information about the wide variety of topics health educators must teach in a comprehensive program. It seems that some college preparation programs in health education are forced to send their undergraduates to different departments for content courses giving them little control over what students are exposed to in these courses. This removes the control over these preparatory programs from the hands of the people most qualified to present the information. In other colleges and universities, content courses may not be considered as important as courses in educational philosophy for example, so students only receive a smattering of the content they will need when they begin teaching. This places the new health educator in the unenviable position of knowing less about health topics than the students they are preparing to teach. The credibility gap develops quickly when you have a class of 38 secondary students, many of whom read magazines and newspapers every day, knowing more about health topics than the teacher. If the health curriculum in a particular state includes 13 different topics ranging from disease to nutrition to sex education, then the teachers graduating from our universities and colleges need to be prepared in all thirteen areas by the health education instructors who are aware of the curricular needs of these future educators. It is not realistic to think that they will somehow be able to prepare themselves in so many areas after they begin teaching 5 to 6 classes each day and handling coaching or club responsibilities after school.

The second role of the health educator is to act as a facilitator in helping students through the decision-making process and the development of other skills related to their health, including refusal skills, valuing, communication skills and the development of self-esteem. There are specific techniques that teachers can use to accomplish these important tasks and these, too, should be included in any preparatory program for health educators.

The role of facilitator is one that many teachers of physical education and science are unfamiliar with, and this is one reason why the inclusion of health education in a variety of disciplines in the school, such as physical education, biology, or home economics, is often unsuccessful and disjointed. Students need to receive the facts, learn how to use the facts and then practice altering behaviors in one class setting, not in five different departments with five different teachers. That is why I have come to believe in the comprehensive school health program. Wellness is a process in which one constantly moves toward becoming the best that is possible. This involves self-awareness, self-esteem, interpersonal relationships, wise choices in the areas of drug usage, nutrition, fitness, and stress management, among others. It is not just sitting around awaiting an unavoidable fate brought on by disease, and then seeking a treatment. Rather, the hallmark of health education today is prevention through selection of a healthy lifestyle.

Our job, as I see it, is to assist students in the pursuit of wellness by providing the necessary information, modeling a process for making wise choices and assisting students in the development of coping and communication skills. This is not to say that a single health education course will be the panecea for all of the problems young people face, but it is a start and well worth our best efforts. Unfortunately, there are a lot of problems to be overcome.

Roadblocks

Accomplishing the two goals previously stated is a tall task for what is often a one-semester course, or less. In many states, like Illinois, there are mandates handed down from the state level telling the health educator what should be included in the health curriculum. These mandates are a double-edged sword. On one side is the fact that many school systems would probably not invest in a health education program at all without the insistence of the state. Since health education is considered by many to be a frill that is not evaluated by state assessment tests or included in college entrance exams,

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it is often an area that is cut when funding becomes scarce. The state mandates may prevent this from occurring. The other edge of the sword, however, is that too much dictation from state authorities concerning content can prevent teachers from developing programs that are meeting the needs of their particular students.

Still another problem facing health education is the qualifications of those assigned to teach health courses. Traditionally, health has hung its hat on physical education, and teachers of physical education were automatically considered to be qualified to teach health. As health education has grown to include many societal and adolescent health concerns, those trained in physical education have found themselves unprepared to teach students about wellness and about coping with today's health-related problems. Some school districts and state certification boards have been very slow to recognize the need for special certification to teach health, separate from certification to teach physical education. The assignment of teachers who are ill-prepared and unwilling to teach health, to health classrooms, has doomed many health programs, short-changed students, and perpetuated the out-dated idea that health education is simply anatomy and fitness. Districts that would never consider placing a math teacher in an English class, do not hesitate to place a physical educator or a driver's education teacher in a health class. Fortunately, other districts and states have noted the need for additional training for those assigned to teach health. For example, in Illinois, we have special certification for health educators requiring prospective health teachers to take certain courses and a specific number of hours. Some districts have required teachers to update their certification before teaching health. Others have not. But one question remains: Are physical educators, whether re-trained or not re-trained, committed to presenting an excellent health program? Are they staying current in the field through professional preparation and reading or do their hearts understandably still lie in physical education? Some make the transition with enthusiasm as I did many years ago, and go back to

school to fill in the courses they need to present a comprehensive program. Others would rather be anyplace but in the health classroom and fail to see the connection between the wellness they should be promoting in the gym and doing the same thing in the health classroom. It is interesting to note that as the mandate for daily physical education begins to be dropped in many states, physical educators are now beginning to hang their hats on health benefits to justify the continuation of a daily physical education requirement. It has taken us a long time to see that the goal of both programs is so similar.

The Future

I would suggest that what is needed at this time is a united approach designed to improve the wellness of students. The health educator, the physical educator and all educators need to work together to present programs that are designed to involve students in the elimination of risk factors that they can control and in the development of a healthy lifestyle. Health education would be far more effective if it were a yearly, on-going program rather than just one semester of health sandwiched in between three semesters of physical education, and four semesters of 8am-4pm classes with no time for lunch. The practice of removing students from physical activity to take health education is counterproductive. At some point, school districts must wake up to the fact that there is more to educating students than test scores in English, math and science... Short-sighted administrators, interested in good public relations with their communities through test scores, have overlooked the fact that the health of a student physically, emotionally and socially is an important factor in achievement academically. The student who is malnourished because of unwise dieting, depressed because of low self-esteem or family problems, over stressed because of poor coping skills or hung over because of last night's beer party is not going to reach potential on any test regardless of the preparation given in academic classes. All educators should be in the business of educating the whole child, but statistics on drug abuse, suicide, teen pregnancy, STD's, and drop-

out rates among youth indicate we are not accomplishing this task as well as we might. Part of the reason is that we have been reactive instead of proactive. Some of the fault rests with the idea that we can measure the success of a school system by the students' ACT and SAT scores. It seems nobody has considered that success or failure in education might also be measured by the rates of drug abuse, suicide, obesity, STD's, teen pregnancy, and violence among students.

If I have learned anything from my students, it is that they want and are willing to accept our help in leading healthy lives. They want to feel good about themselves as people, not just as students, and they are willing to invest even their free time in programs that will assist them in the pursuit of these goals. The task ahead of us, as health educators, is to convince those who determine the emphasis in our schools that: "The health of the people is really the foundation upon which all their happiness and all their powers as a state depend." (Disraeli, 1877)

CHAPTER 14

HEALTH EDUCATION AND THE PURSUIT OF PERSONAL FREEDOM

John R. Seffrin, Ph.D.

Although too rarely achieved, good health is a worthy goal and a time-honored value in societies worldwide. While the achievement of good health is a significant and dynamic end point, it is the means - the possibilities - good health provides which makes it a fundamental prerequisite to the fullest realization of one's human potential. Therefore, any society which aspires to promote full human development among its citizens must place a top priority on those programs and processes which are most likely to assure personal and public health.

The Health/Freedom Connection

Over time, much of our professional literature has discussed the importance of health education in enabling individuals and communities to achieve higher levels of personal and public health. These discussions have clarified state-of-the-art methodologies and they have documented potential positive outcomes, including reduced morbidity and mortality, economic benefits, and overall improvements in the quality of life. Without question, these are extremely important justifications for our existence as a profession, and they also provide a compelling case to make health education an integral part of health care reform in the U.S.

Another qualitatively different rationale exists for health education which is often overlooked or only alluded to by weak implication. I believe the most fundamental outcome of health education is

the enabling of individuals to achieve a level of personal freedom not very likely to be attained otherwise.

As recent history in Eastern Europe and contemporary events worldwide demonstrate, people cherish personal freedom and are willing to give their lives in its pursuit. While we most often think of freedom in the political sense, its ultimate manifestation in life is reached within the individual.

What is Freedom?

Freedom means much more than living in a democratic society where you have the right to vote and to speak freely. It means being able to avoid any unnecessary encumbrance on one's ability to make an enlightened choice. Of course, humanity's common concern is for freedom from, as in freedom from tyranny. However, once this freedom is gained, it allows us to pursue the ultimate freedom—the freedom of, as in the freedom of our innate abilities or our unrestricted talents.

Camus said that, "Freedom is but the opportunity to better ourselves." Rousseau defined freedom as, "the power to choose our own chains." Robert Frost described it as, "being comfortable in your harness." Regardless of which definition or metaphor you choose, it is important for us to understand that to be truly free means being empowered to make an enlightened choice. Making a decision is the most constant aspect of conscious human life, and it constitutes life's heaviest burden, but also its greatest opportunity. Thus, it behooves any nation to do all that is possible to prepare its citizens for a lifetime of making informed choices.

Why Health Education is a Right

"Access to the means for the attainment and preservation of health is a basic human right." This long-standing principle of public health is particularly important today as we address the issue of health care reform. What is perhaps subtle but necessary to realize is that, "access to the means for..." must, in the modern world, be interpreted to mean access to health education as well as access to basic

health care.

At its core, health education is a systematic process which empowers people intellectually to make enlightened choices about their health behavior. Sound health education is designed to promote human dignity, to respect personal and cultural values, and to protect individual autonomy. When successful, health education results in the individual being able to make informed decisions regarding one's own health behavior which ultimately maximize the prospect that he or she can become self-actualized.

The stark reality that most of our nation's 46 million cigarette smokers became addicted to cigarettes without access to comprehensive school health education and before reaching the legal age required to purchase the product dramatizes why sound health education is so vital to our nation and its future. Not only does tobacco addiction exact an unacceptable burden in health care costs (about $65 billion annually) and a true carnage in human lives (20% of all deaths in 1993), it also strips one-fourth of our population of significant freedom of choice (addiction is a form of bondage) and it sets an unnecessary and undesirable limit on each smoker's human potential.

No better example exists to demonstrate the moral imperative of health education. For school-age children to have easy access to illegal tobacco products, and for them to be deluged rapaciously with misleading and alluring tobacco ads, and yet not be exposed to sound health education, is a moral outrage in any society, and especially in one which prides itself on human rights.

Lessons Learned

As we approach a new century and a new millennium, it is important for us to look back and ask, what have we learned during the 1900s? Following are six lessons which can help us determine what directions we should take in the future, if we are truly committed to improve health and promote individual freedom.

Lesson I. The leading causes of death change over time.

At the beginning of this century, tuberculosis was a leading killer. Today, heart disease and cancer have taken its place. From a health education perspective, it is incumbent upon us to focus on common linkages in behavioral etiology and not on the disease entity itself. This is why the American Cancer Society, for example, has decided to emphasize comprehensive school health education rather than site-specific cancer education for children and youth.

Lesson II. Our ability to cure is limited, difficult, expensive, and often disappointing.

We will always need to find better and more effective ways to cure disease; however, it is imperative for us to realize that cure at best is second-best. What is more, if we look at recorded history, we find that no major epidemic has ever been brought under control by any means other than prevention.

Lesson III. The possibility of and opportunities for prevention are extraordinary.

Regardless of the disease process, the window of opportunity is almost always more open to intervene with prevention than it is to other avenues of disease control. Health education and health promotion are not only valid ideas, they are also attractive options because the opportunities to intervene are many and varied. From comprehensive school health education to media campaigns, like the Great American Smokeout, to one-on-one health counseling, myriad chances exist to intervene before the disease process begins or becomes clinically significant.

Lesson IV. Prevention is virtually always less expensive than cure, and it is more satisfying and consistent with quality of life.

It is both literally and metaphorically true that, "an ounce of prevention is worth a pound of cure." For instance, the cost per patient-year of life saved for lung cancer is about 90 times more expensive than preventing it! Moreover, the quality of life for someone without lung cancer is incomparable to the life of someone who has had the disease and has been treated with conventional methods, i.e.

major surgery, radiation and chemotherapy.

Lesson V. Human behavior - its development and its change - is the most important and most difficult part of prevention.

We have a long way to go before truly understanding the complexities of human motivation and human behavior. However, we now know enough to take positive action with our educational efforts. We know what doesn't work, and we know that well designed interventions can be at least partially effective without being coercive.

Lesson VI. Health education and health promotion have yielded significant and positive results with relatively little investment.

We often bemoan the fact that many of our efforts in health education don't work well—and none works perfectly. In reality, it's remarkable that we do as well as we do. There are numerous examples, but suffice it to point out that with little financial support, and in the face of an annual multi-billion dollar tobacco advertising and marketing campaign (tobacco is the most advertised product in the world), 44 million American adults have successfully quit smoking since the anti-smoking education campaign began. A smaller percentage of adult Americans are smokers today than at any time since the original Surgeon General's report in 1964. This outcome represents one of several major health education success stories which have saved hundreds of thousands of lives in the latter decades of this century.

During this century the aforementioned observations and experiences lead us naturally to draw new conclusions and to understand more fully these immortal words:

"We have done those things we ought not to have done and left undone those things we ought to have done and there is no health in us."

[From the Book of Common Prayer]

Of the many lessons learned during the 20th century, these six lead

us inescapably to one overriding conclusion: to wit, any successful plan to further improve health status in the United States must necessarily include a major commitment to behavioral science and health education.

Principles and Practices

As we work to improve our profession, and thereby the health and quality of life for all people, we should strive to synthesize our lessons learned into a meaningful set of conduct standards for contemporary professionals. In other words, beyond basic competency, what will it take to be an effective professional health educator in the future?

The future of health education is brighter than ever before; however, the challenges are great and the demands on the practitioner will prove to be unprecedented. To compete successfully in an ever-changing world, we will need to be resourceful and open to change. In fact, we need to understand that the only responsible response to change is to change ourselves. In so doing, however, we need to change in ways that do not violate certain basic principles. Most important among these principles are:

1) appreciation for each individual's uniqueness;
2) respect for ethnic and cultural diversity;
3) protection of individual and group autonomy;
4) promotion and preservation of free choice; and
5) intervention strategies based on good science.

To be maximally successful and consistent with the above-mentioned principles, today's health educator needs to see his or her role large. Beyond basic competence and using state-of-the-art techniques, the health educator needs to:

1) Lead by example.

   None of us is perfect. However, within our own limitations, we should do our best to exemplify the principles we espouse.

2) Collaborate more with others who have common

concerns and mutual interests.

Over the years, we have been guilty of talking too much to ourselves. If we work only with other health educators we will never reach our goals, let alone the true potential of our profession. We must take the leadership role in working with other groups to effect change.

3) Read broadly.

As Dr. H. S. Hoyman told his graduate students, "If you read only in your field, you are not well read in your field." Part of seeing your role as a health educator large is the process of linking up what we do with the most fundamental aspects of our human condition. This can only be done through life experience and spending time reading literature beyond our field.

Following are a few suggested titles which have been helpful to this author. Full bibliographic information is given for these and other suggested readings at the end of this article.

* Complete Poems of Robert Frost
* The Phenomenon of Man
* Toward a More Natural Science: Biology and Human Affairs
* In Search of History: A Personal Adventure
* Savage Inequalities: Children in America's Schools
* Within Our Reach: Breaking the Cycle of Disadvantage

4) Advocate strongly.

Because our profession sets goals and works toward measurable end points, we as practitioners are change agents. To be successful as change agents, we must do more than just teach, research, and serve. To be truly effective, we must also persuade and advocate for social change. We must vote with our voice and our feet, as well

as with our ballot. We must constantly remind ourselves that poor health is one of the most significant and pervasive factors limiting human growth and personal freedom worldwide. To change this reality will necessitate strong advocacy for bold change. It won't happen unless we too speak up!

In the short history of health education, there has never been a better nor more exciting time to be a health educator. Decades of experience, along with growing and increasingly sophisticated professional literature, have allowed us to document our effectiveness. Moreover, the world has changed and so has its needs. Contemporary public health problems are largely immedicable woes which are highly amenable to resolution through health education and health promotion interventions. Prevention in general, and health education in particular, also represent extremely attractive alternatives to society when economics and human values are considered in the overall analysis of what direction to take to improve public health.

Suffice it to say we now have the way, but we must generate the will. If we do, we can change state-of-the-art in health education into state-of-the-practice, and thereby, we can be an important part of changing what is into what ought to be.

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